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THE EFFECTS OF PPS ON QUALITY OF CARE FOR MEDICARE PATIENTS

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#204

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

LOS ANGELES, CA

JANUARY 7, 1986

Serial No. 99-14

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THE EFFECTS OF PPS ON QUALITY OF CARE FOR MEDICARE PATIENTS

TUESDAY, JANUARY 7, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Los Angeles, CA.

The special committee met, pursuant to notice, at 9:15 a.m., Veterans' Administration Hospital, Brentwood Theatre, Los Angeles, CA, Hon. Pete Wilson, presiding.

Also present: Maria Schutz, legislative assistant and David Schulke, investigator.

OPENING STATEMENT BY SENATOR PETE WILSON

Senator WILSON. Good morning, ladies and gentlemen. Welcome to this hearing of the U.S. Senate Special Committee on Aging. I am Senator Pete Wilson, a member of that committee.

Seated to my left are David Schulke, investigator for the committee, and my legislative assistant, Mrs. Maria Talavera Schulz who has responsibility in a number of areas but relevant to this morning's hearing, that of health care.

Can all those in the audience hear me? I see a happy smile in the back, makes me think not.

I am very grateful to our witnesses for being with us this morning. I am grateful to those in the audience who have taken the time to be here to share with the committee concerns that have prompted this field hearing. This is one of the very first field hearings on this particular subject to be held by the committee. We have had hearings in Washington on a particular concern that faces not only the Committee on Aging, but all those who are involved with the health care of America's elderly.

John Kennedy said many years ago that "to govern was to choose." If you have been reading the newspapers even casually, you will note that in Congress we have been compelled finally to make a number of our choices. But what is clearly the case for a civilized nation is that however we are compelled to come to grips with the reality of reducing the deficit, we cannot do that in a way that ignores the health care needs of our elderly population. Let me be considerably more specific.

You the taxpayers help support a Medicare system, that is a system by which we fund health care for the elderly which this past year cost over $70 billion, a lion's share of which was paid to hospitals. Stop for a minute to think about what it is that you are getting for that $70 billion. You are getting the finest health care

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system in the world—bar none. You are getting the foremost technology, the best network of support services, the premier cadre of doctors and other health professionals. In short, thanks to the generosity of the American people, we enjoy a level of health care and coverage unmatched for personal attention and state-of-the-art expertise that exists anywhere in the world. But, it is a system that would appear to have flaws, in fact it is inevitable, given its size and scope and the scale upon which we operate, that it will have flaws, so we must be careful to assure ourselves that these are merely anecdotal incidents—that they are subject to redress because they are not systemic flaws.

As the old cliche has it, if you have your health, you have everything, and another cliche that has become deservedly a truism, is that you get only what you pay for.

This society must be prepared to recognize its obligations to preserve the well being and to protect the options available to our elderly. No one certainly has spoken out more often or with greater conviction than I have about the need to cut Federal spending, to eliminate waste, to reconcile revenues with expenditures, lest we be plunged back into the kind of recession from which we have all too recently escaped. But I believe we must insist, as a civilized nation, that we are never guilty of premature discharge of an elderly patient from a hospital. We cannot send home someone who is not well simply because the accountants require in the schedule, that their time is up.

Now, I do not say this to demagog an issue which is enormously complex and difficult, for we are not here to scapegoat anyone, because the issue is far too important. We are here to focus upon what problems exist and to cure them. It will not be easy, but neither is it impossible. This is not an intractable problem. It is one that requires our careful attention and refinement of the efforts that were begun in 1983 which Congress, in recognizing the necessity to curb runaway health care costs, imposed a new payment schedule upon health care providers.

Before us in this hearing then is the question of how to balance the needs of adequate health care for the elderly and legitimate demands for economic austerity that are reflected in a time of stringent budget cutting. While we must retrench in many areas, we cannot retreat from the goal of decent care for America's elderly.

Based on preliminary reports from the General Accounting Office from a host of elderly patients, doctors, and other health care providers, who have previously appeared before the Senate Special Committee on Aging, we know that a problem exists. That problem regards the way that hospitals now get paid for providing care to Medicare patients.

This morning you will hear from representatives of every group effected by these changes. We will hear from patients. We will hear from their firsthand experience. We will hear the administration's assessment of how the prospective payment system is working, that being the system instituted by Congress 2 years ago. I emphasize it was just 2 years ago and it is probably only just now that we have a reliable basis and experience for judging how that system is working or failing to work.

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We will hear from our own peer review organization which has been entrusted with monitoring the system in its first months of operation. Hospital administrators will share their thoughts with us, as will physicians and, those who deal with posthospital care.

This is the time for being honest with ourselves and with one another so that we can in fact do the job that is required of us, at a time when demands are great, yet resources are clearly very tight. We have need for the kind of imagination and creativity, and above all else, the information that will allow us to make the necessary adjustments so that we can first assess where we are and where we must go, and then take the steps necessary to get there.

Our goal was simple to state, even if the process of getting there is difficult. The way we choose to pay our hospitals for services that they are providing, appear to have caused an ironic, and in some cases, even a cruel reduction in the level of care available to Medicare patients. We need to reconcile what America can afford and what our conscience as a nation demands that we provide to assure ourselves that our elderly citizens are receiving adequate, decent, health care.

The very questions themselves as you will learn this morning from the detailed testimony that we will receive, are not easy to formulate. That's why we are here, as John Kennedy said, "to govern is to choose." One choice, I think, is clear. We are going to provide health care of which the American taxpayer, can be proud, and of which the health care professionals can be proud. We are going to see that we do that in the most efficient way possible.

Out of this forum and others, we will learn, what it is that must be done. Let me now, as we move to the first of our witnesses, state again, that we are grateful to them for being here to provide the information without which we cannot make the difficult judgments that are required in order to move forward. We will receive some very detailed recommendations. And from this hearing there will be legislation—legislation from this and the other hearings, will be presented for hearing by the Senate Finance Committee, specifically by the subcommittee that deals with Medicare health services delivery.

We are here to educate ourselves, to sensitize the general population to this conflict between resources and responsibilities, and I think that we are particularly fortunate in the hearings that we have had in Washington, that allowed us to hear from patients and providers in the East, the South, and Midwest. California, because of its large elderly community, is of special importance. This field hearing has afforded us an opportunity that I think is required in order to have a complete picture of health care for the elderly in America.

This morning we will hear from three panels, the first of these consists of Mr. Jack Gould who is a Medicare recipient, a patient, and resident in Los Angeles. His testimony brings to us not the common experience, but the rather remarkable experience of someone who through his own experience, was able to, I think, provide testimony that few other patients could.

The paper trail that is involved in health care delivery is impenetrable to most, his personal expertise, I think, has allowed him to bring to us a rather singular story.

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We will hear next from Ms. Eva Skinner, a registered nurse, a member of the Gray Panther's National Advisory Board, and a member of the Peer Review Organization here in California, the California Medical Review, Inc.

We will hear from the Associate Administrator for Management and Support Services of the Health Care Finance Administration, which is the Federal Government's agency in charge of administering this very difficult program. Mr. Bart Fleming is with us as the Associate Administrator and Administration spokesman.

Finally, our last witness in the first panel will be Dr. William Moncrief, president of the Peer Review Organization, or as we will refer to it this morning, PRO. It is the organization to which has been entrusted the very heavy responsibility of monitoring the provision of these health care services.

Mrs. Skinner, let us begin with you. We are very grateful to you for being here, and your testimony is not only useful, but it contains some of the specific recommendations that I mentioned, and we are very eager to hear from you.

STATEMENT OF EVA SKINNER, R.N., LOS ANGELES, CA, CALIFORNIA MEDICAL REVIEW, INC., AND MEMBER, GRAY PANTHER'S NATIONAL ADVISORY BOARD

Ms. SKINNER. Good morning, Senator Wilson. I am happy to be here. I really do appreciate the opportunity to talk to you and to the people gathered here.

I think we have a serious problem on our hands in relation to health care, not only from the standpoint of the financial picture, but also in terms of the quality of care that our older persons are getting.

Now, I speak to you as a Medicare recipient. I do want to stress the fact that even though I am going to tell you about some cases that have come to our attention, I still want to speak as someone who is a senior, who has experienced the problems of older people and illness, and who is very concerned about it both on a personal level and on a professional level as well.

I think we all know that the health of older persons particularly depends on many factors in addition to physicians, nurses, medications, therapists, et cetera.

Unfortunately, in designing the new system for payment to hospitals based on DRG's, many of these factors were not taken into consideration. When the patient is discharged from the hospital, because we do not have the adequate services, do not have the adequate planning for the posthospital care of the older person, these often are the determining factors on whether or not the person will recover to the best state of health possible. We find this happening again and again. I am sure that one of the other witnesses will discuss in more detail community services, but I feel this must be mentioned by all of us because it is a part of quality care and it must be considered when we discuss what is happening with the DRG's and the PRO's.

Let me run through several cases that have come up. These are documented cases and they can be verified if need be.

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The first one is an 81-year-old woman who is a widow, who has no children, no near relatives, and who has had for some time, Parkinson's disease which is a condition that makes it difficult and sometimes impossible for people to take care of themselves.

She was admitted to a hospital for a radical mastectomy, meaning that the breast was to be removed for cancer. She was discharged from this hospital within 24 hours after the surgery.

A radical mastectomy is a very shocking, physical, and psychological procedure. In addition to which this woman was not able to administer her own medication, et cetera, because of the Parkinson's. She was not able to take care of herself. Had there been a longer stay in the hospital until she was more recovered from the trauma of the surgery, and had there been adequate community-based services available, she could have gone directly home after a longer stay in the hospital. Instead she was sent to a skilled nursing facility where she remained for 10 days, and she had to pay for all of that out of her very meager savings because she had not been in the acute hospital the required 72 hours before she could receive the Medicare benefits from a nursing home placement.

The second case that I want to talk about is a 76-year-old woman with chronic obstructive pulmonary disease, a serious lung condition. The woman also has high blood pressure and is really quite ill with all of these. She was admitted with a high temperature and a very fast heartbeat. She was discharged from the acute hospital within 24 hours and given by her physician, nine medications to administer to herself, and without any further observation.

Unquestionably, this was a premature discharge, both on the part of the hospital and the physician. There should have been better discharge planning, there should have been better community services available for this woman, but primarily she should have remained in the hospital longer.

The next patient is a 67-year-old man with a history of high blood pressure and a serious heart condition. He was admitted to the hospital, discharged within 24 hours, and not followed up after the initial electrocardiogram. He went home with what could be considered a serious life-threatening condition.

The fourth case is a 76-year-old man with a history of kidney failure and high blood pressure. He was admitted with dizziness and a very slow pulse, discharged from the acute hospital 22 hours later, after having been misdiagnosed and certainly undertreated.

The fifth case is a 66-year-old woman with a past history of high blood pressure. She was admitted complaining of a new chest pain and fainting. She was discharged within 24 hours without any cardiac workup. We don't know what this woman had. We do know that she was quite ill when admitted. She was inadequately worked up by the medical staff when she was in the hospital, and once again she was discharged much too early in terms of her life-threatening condition.

The next case that I would like to talk about is an 81-year-old man with a previous history of stroke which left him paralyzed on his right side. He was admitted to the hospital because of a decreased level of consciousness. He had a temperature of 101 degrees which is high for an older person, and he had previously been diagnosed with a urinary tract infection. When admitted to the hospi-

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tal, his diagnosis was that of a stroke. He was discharged after 4 days to a nursing home without any effective treatment of his urinary infection which could very well have been a generalized septicemia. He was discharged to a skilled nursing facility, he was readmitted to the acute hospital 1 week later because he was getting more seriously ill, and he died the next day in the hospital.

This was a life-threatening situation, he was diagnosed improperly, he was treated improperly.

These are just six of the cases which have come before the PRO to be evaluated. These are samples of cases on which the PRO has moved and recommended quite serious sanctions because of the lack of quality care; and these are some of the cases that we hope that the inspector general will follow through on sanctions that the CMRI has recommended.

I do want to say that the California PRO leads the country in dealing seriously and vigorously with these sanctions, and we hope that it will bring about the result of better care for all the older people, for everyone in the country.

Thank you, Senator Wilson.

Senator WILSON. Thank you very much.

[The prepared statement of Ms. Eva Skinner follows:]

PREPARED STATEMENT OF EVA SKINNER

SENATOR WILSON: My name is Eva Skinner. I am one of California's nearly three million Medicare beneficiaries. I am here today to give you my perspective on Medicare Peer Review Organizations and the role of PROs and the federal government in assuring quality health care for the nation's elderly.

Although I am just one of millions of Medicare beneficiaries nationwide, I bring a broad perspective to the issue you are discussing today. For more than 45 years I worked as a registered nurse. I have been active in health care issues affecting senior citizens in California and nationally for more than two decades. I am also an active member of the American Association of Retired Persons and currently serve on the national advisory board of the Gray Panthers.

In addition, I am one of two Medicare beneficiaries serving on the Board of Directors of California Medical Review, Inc., the California PRO, and one of only eight Medicare representatives currently serving on the 54 PRO boards nationwide.

Since the inception of Medicare's Prospective Payment System, I have been deeply concerned about the quality of health care services provided to Medicare beneficiaries. I have been watching the PROs with great interest to see how they identify and address quality of care problems. Through my work with California Medical Review, I can say that I am pleased with the serious intent of this PRO and the commitment of its staff and physicians to render quality health care while working to reduce unnecessary hospitalization and costs under Medicare. However, much more needs to be done in the area of quality assurance by the federal government and PROs nationwide.

In particular, California Medical Review is setting a good example of quality assurance activities other PROs should be initiating. Last month, after thorough and careful investigation, CMRI recommended to the office of Inspector General of the Department of Health and Human Services that three physicians and one hospital be sanctioned for providing inappropriate or substandard care to Medicare patients.

These recommendations, among the first in the country, have established a precedent for PROs nationwide and sent a warning to the hospital and physician community that PROs are seriously committed to maintaining quality health care delivery despite mounting pressure on the part of the federal government to control skyrocketing health care costs.

The response from the Office of the Inspector General will reinforce the message that hospitals and physicians will be held accountable for their action or inaction. California Medical Review is currently finalizing more than 20 additional sanctions and expects its review activities to produce another 100 sanctions by the end of 1986.

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Education is another quality assurance activity being conducted by California Medical Review that needs to be emphasized in all state PRO programs and by the federal government. Acronyms such as PPS, DRGs, HMOs and PPOs remain alphabet soup for the majority of our nation's senior citizens. The bottom line is that seniors need to know their health care rights and how changes under the Prospective Payment System affect their health care delivery to avoid becoming victims of compromised care.

To better educate California's Medicare beneficiaries, California's PRO recently released guidelines to local media outlets as well as federal and state legislators outlining questions Medicare patients and their families should ask their physicians and hospital representatives. The purpose of these guidelines is to enhance quality of care, avoid premature discharges, plan for care after hospitalization and, in general, encourage patients to become partners in responsibility for their health care. In addition, California Medical Review's staff, local physician-employees, Board members, and I have been conducting outreach to senior citizen groups throughout the state to further educate them about the Medicare system and their rights as Medicare patients.

In addition to CMRI's efforts, the Gray Panthers recently released guidelines to senior groups throughout California and the American Association of Retired Persons has compiled an excellent booklet titled Knowing Your Rights which has been distributed nationwide.

While these educational programs are to be commended, the federal government cannot continue to rely solely on senior citizen groups and Peer Review Organizations to educate the public about the government's health care delivery system. To better educate the nation's senior citizens about health care under Medicare, I urge the federal government to: establish a national toll-free Medicare informational "hotline" to give beneficiaries immediate access to needed Medicare information; require hospitals throughout the country to provide standardized information to senior citizens, upon admission, detailing their health care rights under Medicare; and, provide regular updated information on Medicare services and care using inserts with Social Security checks.

In addition, the federal government, hospitals, doctors and PROs must provide seniors with consistent and accurate information about Medicare.

On the national level, there must be a greater commitment on the part of the Department of Health and Human Services for adequate funding of state PROs to help reinforce, strengthen and expand their mandated quality assurance authority in sanctioning hospitals and physicians providing inferior or substandard care.

All PROs have the ability to sanction, yet after more than a year's operation only two PROs have recommended sanctions to the Office of the Inspector General.

The members of the organizations I represent are quite aware of this committee's concerns about premature discharges. The Health Care Financing Administration has made strides toward reducing the incentive for hospitals to apply pressure for early hospital discharges by instructing PROs to deny payment to a hospital for a second admission that results from premature discharge.

I encourage the federal government to continue working to prevent hospitals from pressuring physicians to discharge patients too soon and to increase support by the federal government for research and more effective quality controls at the PRO level for identifying, assessing and preventing a broad range of quality of care problems.

In addition, as cost containment pressures drive more and more patients from hospital beds into nursing homes and other outpatient care facilities, it is critical that PROs be given greater authority and funding by the federal government to review patient care in these facilities—beyond the corridors of the hospital.

Preadmission certification for skilled nursing facilities as well as additional planning and funds for community based services such as home health services for personal care, transportation and meals for the post-discharge patient are also needed to assure quality care and effective use of health care resources. As a result of early discharges, elderly patients are often channeled into skilled nursing facilities whether or not that level of care is needed. If proper planning and post-discharge levels of care were available in this country as they should be, the increasing number of elderly patients sent to nursing homes would be reduced dramatically.

Most important, Medicare beneficiaries need to be involved at the local, state and federal levels in Medicare and PRO policy development. Toward this goal, I urge PROs to act upon a nationwide drive underway by AARP to have Medicare beneficiaries serve on all PRO boards. While consumer advisory panels could provide valuable input, greater representation of beneficiaries on PRO Boards will give Medicare patients a voting presence on issues that critically affect their lives.

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I know I speak for the more than 27 million seniors enrolled under Medicare nationwide in this country in saying that we want and deserve to be involved in protecting our access and right to quality health care now and in the future.

Senator WILSON. Next we will hear from Mr. Gould.

STATEMENT OF JACK GOULD, MEDICARE RECIPIENT, LOS ANGELES, CA

Mr. GOULD. Senator Pete Wilson and members of the Special Committee on Aging, it is a pleasure and an honor for me to even be here to present testimony to you on the impact of current hospital payment practices on the quality of health care for elderly patients. I particularly wish to tell you, Senator Wilson, that I appreciate your opening statement very much, and on your cliche which applies to me, "if you have your health, you have everything." Really, I believe that.

I really have it; I have entered well into my 80th year of living and I really have a quality of life right now that is exceptional. I wish I could say the same about the past 3 years which I will briefly get into. It is well covered in the testimony which I have presented to you.

I address you with a decade of service as vice chairman of the Affiliated Committees on Aging of Los Angeles County, with my first public statement in 3 years, having had 13 hospital stays since January 1, 1983.

I was an engineer in management, metallurgy, and quality control for over 40 years prior to the first of many retirements. The last full employment as an engineer included assuring the quality of small-size hydraulic line stainless tubing for the jet engines of jumbo airplanes which are flying today and I would peer into the inside of those tubes to make sure that there was no defect present. Life-threatening situations for many passengers would be involved if only one small defect resulted in a tube failure.

That is a type of quality control, for which I was fully responsible. So, I am well aware of the need for quality control where life-threatening situations are involved, eliminating any cost-savings consideration where defects could be present. Quality control of steam generator tubing for nuclear-powered vessels, ships, and submarines were also my responsibility.

I have taught public benefit programs, subsequent to paralegal training by the State of California and the National Paralegal Institute. Then at the age of 73, I obtained employment with a carrier for the Medicare Part B Program, and I became chief liaison contact between beneficiaries and the system of Medicare in southern California, specializing in beneficiary education.

My 1983 series of hospitalizations resulted in my voluntary resignation after 4 months of sick leave.

Five of the thirteen hospital stays referred to have been under the DRG system. I was in the hospital at the time the DRG PPS program was put into effect.

I was also a member, for 5 years, of one of the allied health professions committees of the State of California which is under the California Board of Medical Quality Control.

My knowledge of hospitals indicates there are many ways, within a hospital with proper administration, that cost reduction can be

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made without affecting quality care, and, in many cases, actually improving it.

When life-threatening situations were involved, zero defects were the goal in industry and that means in health as well. We are certainly at an age of rapidly changing medicine and surgery; where there are many near miracles, some of which I have been the recipient. These miracles occur with organ transplants, fantastic medications, the use of lasers in many ways and in so-called defensive medicine of which I have seen very much.

The need for cost reduction from the escalating costs of health care for the elderly is of extreme importance and is the main issue at hand. It should involve seeking out and eliminating the waste and duplication of services and elimination of purely defensive services. The physicians themselves play a very important part in this, but in my experience, are the least qualified to actually implement much of the actual cost reduction. They need help to do so. I find the quality control type people in many of the hospitals that I have been in, are inadequate. I will give you a very simple quick example of this.

I wanted to get a telephone device for the deaf [TDD] when I was in one of the hospitals, and the quality control person there, said to me, "Oh, these stupid idiots, we have several here, I'll send one in to you." An amplifier for the telephone was brought in. I was not deaf; my wife is hearing impaired and I needed the TDD to converse with her by telephone. I knew they had the instrument, it was in the emergency room, I had used it before, but the quality control person did not even know it existed, nor what it was.

Let me briefly mention to you that when I was in the hospital—I had two DRG rejections after being admitted to the hospital, and went through all the steps of trying to exercise my rights, and believe me, I know how to fight the system, but I got nowhere. I eventually had one case reach the administrative law hearing with Social Security. I knew I was not entitled to it because I did not have over $100 involved. The attorney in the Social Security office informed me that the only way that any change in the PRO system could be accomplished was through my elected official in Washington, so here I am.

The testimony indicates that it would have been gross malpractice on the part of my attending physician not to have admitted me to the hospital under the circumstances. He knew what my past history was in great detail. He had indicated to me what the possible situations were that were involved, concerning my abdominal attack. The 2-day hospital stay, from the emergency room, which was denied and later accepted (it is not known by whom) with no reason given, did not solve the problem at all. This was in a not-for-profit hospital, and the data shows that a pediatrician, signed the order stating that the hospital stay was not medically justified.

I was subsequently admitted, with identical pain, to a teaching hospital where I remained for 20 days. During this period there were two invasive surgical procedures with two separate 1-day stays in intensive care and a 1-day stay in critical care. I was readmitted 30 days later for an additional 6-day stay with one invasive surgical procedure.

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The miracle of effecting a cure was apparently found, and I was restored to feeling like a young college student again. That is the way I felt when I left the hospital and how I feel today.

I think I will leave it there and leave the balance of my testimony to any questions that you might like me to address.

Senator WILSON. Thank you very much, Mr. Gould. Your statement in full as Ms. Skinner's will be made a part of the record. That is true of all the witnesses this morning who have submitted written testimony. In your case the extensive appendixes are welcome. I think they well document the administrative struggle which you described very briefly in your oral testimony. We thank you.

[The prepared statement of Mr. Gould, with attachments, follows:]

PREPARED STATEMENT OF JACK E. GOULD

My name is Jack Gould, address 11734 Wilshire Blvd., Los Angeles, California 90025.

Senator Wilson and members of the Special Committee on Aging, it is a pleasure for me to present testimony to you on the quality and delivery of in-hospital health care under the Medicare program.

I became eligible as a Medicare beneficiary on July 1, 1971 and have had approximately 20 hospital stays since that time—with benefit periods of from one to 28 days. I directed a demonstration health screening clinic in Los Angeles and Santa Monica in 1973 which later developed into what is now the Peer Counseling Clinic in Santa Monica.

I was a regional director of the SSI alert program in 1974 and later taught in the Los Angeles City Community College system on the subject of public benefit programs.

At the age of 73 I was employed for four years by the Southern California Part B Medicare Carrier in various capacities which brought me in direct contact with beneficiaries on how to properly submit forms and claims and to their rights as beneficiaries. I resigned in mid-1983 after returning to work after 4½ months of sick leave, due to physically and mentally being unable to work at a satisfactory level. During the sick leave I had five hospital stays and four major surgeries. During the remainder of the year there were an additional four hospital stays, for a total of 81 days for the calendar year. I have been exposed to a plethargy of hospital tests many times during the 13 hospitalizations which I had from January 1, 1983 to the present time. I have also had several very expensive tests on an experimental basis on research programs which were not covered under the medicare program.

There have been two hospital stays which were denied by CMRI Inc. (PRO in California). One stay was for one day; this was the planned length of stay, denied as medically not justified, but covered for an unstated reason. This was in mid-1984, for the removal of a colon polyp which proved to be benign. The second stay from November 6, 1984 after an admission from the emergency room of a large not-for-profit Los Angeles Angeles Medical Center, was denied after two days, stating that my doctor had agreed that admission was not medically necessary.

Following are the exhibits which relate to the two hospital stays:

Exhibit A, October 26, 1984, is a notice of Medicare Part A claim determination with a hospital stay of July 10–11, 1984 which is a denied hospital stay of one day.

Exhibit B, Letter of November 2, 1984, which was hand delivered to me in the hospital on November 8, 1984, from the Medical Center utilization review committee notifying me that in conjunction with the attending physician, they had determined that my admission from the emergency room did not require an acute level of care, and denied a hospital stay from 11/6—11/8/84.

Exhibit C, Letter of November 14, 1984, from me to Blue Cross appealing the denial. Blue Cross is the intermediary involved.

Exhibit D, dated December 6, 1984, an acknowledgement of the above request.

Exhibit E, Letter of March 4, 1985, from CMRI stating review determination of the hospital admission stating that the hospital admission is not medically necessary.

Exhibit F, Letter of March 9, 1985 from me to the District Director of CMRI, District 4, requesting reconsideration of the denial.

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Exhibit G, March 25, 1985 reply from CMRI, reconsideration denial.

Exhibit H, April 16, 1985 letter from my attending medical doctor to CMRI stating that it would have been gross malpractice for him not to have admitted me to the hospital.

Exhibit J, April 20, 1985 letter from me to HCFA, requesting a review of reconsideration denial.

Exhibit K, January 8. 1985 Medicare benefit notice stating that the medicare benefit notice of 11/6/84 to 11/8/84 hospital stay was paid except for $356 deductible.

Exhibit L, April 11, 1985 letter to me from Cedar Sinai Medical Center apologizing for stating that the attending doctor had approved the denial.

Exhibit M, May 17, 1985 Notification from Social Security Administration of administrative law judge hearing.

Exhibit N, July 8, 1985 Notification to me by Judge Bodner that hearing filed 4/20/85 was dismissed as not meeting criteria for hearing.

In reviewing the exhibits, let us look at Exhibit A, the denial of a one day hospital stay, that certainly seems like an exercise in futility. The stay was denied and later paid and there is no indication as to why this hospital stay was eventually accepted. With the history that I had had of previous emergencies, a heart condition and surgeries, this stay was to observe me prior to a colonoscopy which was similar to that which President Reagan had—fortunately in my case the biopsy was negative.

Let us now take an overview of Exhibits B through M. Basically this involved a hospital stay which was terminated after two days when notice was served that the hospital stay was not justified. The admission in this case was from the emergency room by the emergency room doctor in agreement with my physician, based upon prior histories and two hours of acute abdominal pain. In Exhibit H, the attending physician states that there would have been gross malpractice involved had I not been admitted to the hospital. The physician review in this case by the CMRI was signed by a pediatrician. I went home very frustrated, wondering if I would make it the next time. A few months later, identical symptoms, resulting in emergency hospitalization, resulted in a hospital stay of 22 days followed by an additional stay of 6 days at a large teaching state hospital. Difficult and very serious invasive procedures and surgery isolated the problem and solved it with fantastic results. Stays in CCU and ICU with blood and plasma transfusions were required for care.

At the time when I spoke with the attorney at the Social Security Administration concerning the scheduled hearing on the denied hospital stay, I was aware that my case did not meet the criteria for a hearing. Since Medicare had approved payment of the covered services for the period involved, except for the deductible, there was no financial consideration involved and I was asked why I had requested a hearing. When I explained to the attorney that it was my objective to have the opinion of the CMRI reversed although someone had already authorized payment, I was told that I should take this matter up with my Congressional representatives, as they were the only recourse. Her experience in trying to reach physicians of CMRI was very unsatisfactory.

During my numerous hospital confinements, as well as hospitalizations of other beneficiaries, I had observed much waste and over-utilization of days in hospitals. Included are such situations as 1) weekends when many required procedures and tests are not available; 2) poor or improper scheduling of tests requiring extra days and 3) poor scheduling of physician visits resulting in tests ordered too late in the day, thus requiring additional days of stay. The present DRG system does not normally make available to patients any prior knowledge of length of stay allowed, and in my case, left me in the same condition upon leaving as when I entered the hospital.

As a result of my experience, I can only recommend a teaching hospital to one who has a serious, undiagnosed illness.

On January 3, 1986, I was given time by my attending physician who did not wish to be identified, so that he could give me additional information. He related to me that many cases similar to my case do occur. He pointed out that in one case, he was finally able to obtain approval of hospitalization for a patient after two denials from San Francisco, after reaching the Chief of Surgery. After the patient was admitted to the hospital for surgery she was again rejected with the statement that hospitalization was not medically justified.

Thank you for the opportunity of allowing me to present testimony to your committee.

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Ex. A.

Notice of Medicare Claim Determination

Intermediary Number, Name and Address
00040
Blue Cross of California
Medicare Claims Department
P.O. Box 70000
Van Nuys, California 91470

Date
October 26, 1984

Your Health Insurance Claim No.
276 03 0015 A

J. E. Gould
11734 Wilshire Boulevard
Los Angeles, CA 90025

Services Provided By: *(Name and Address)*
[redacted]

Provider Number
05-0625

Type of Service Provided	Date of Admission or First Visit	NOTICE COVERS PERIOD	
		FROM	THROUGH
☒ Hospital ☐ Skilled Nursing Facility ☐ Home Health Agency ☐ Other ____	07/10/84	07/10/84	07/11/84
	Insurance ☒ Hospital ☐ Medical		

This concerns the services you received from the facility shown above. Medicare cannot pay for the above services for the following reason:

Medicare will cover inpatient hospital care furnished a patient but only if such care is reasonable and necessary for the treatment or diagnosis of the patient's illness or injury and is of a type that can only be provided on an inpatient hospital basis.

Since the services you needed did not meet this requirement, no hospital insurance benefits can be allowed for your stay.

HOWEVER, your responsibility for payment of services received has been relieved because of a special provision in the Social Security Act. See paragraph (1) on the reverse side of this notice for more information on the waiver of liability provision which pertains to this claim.

hospl/1954
mj/0284d

Important: See other side for an explanation of your appeal rights and other information.▶

Form HCFA-1954C(3) (8-77) Formerly SSA-1954(C)(3)

1 - BENEFICIARY COPY

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If you have any questions about this notice, you should first get a detailed explanation from your social security office. If you still believe the determination is not correct, you may make a request for reconsideration for Hospital insurance (or a review for Medical insurance). For Hospital insurance, you must file your request within 60 days from the date of receipt of this notice. For Medical insurance, you must file your request for a review within 6 months from the date of this notice. You may make the request through your social security office.

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Ex. B.

[redacted]

Reply to Box [redacted] Los Angeles, California [redacted]
Direct Dial Number

Quality Assurance
855-3068

November 7, 1984

Patient: Gould Jack E.
Medical Record #: 14/194598
Admission Date: 11/6/84

Dear Mr. Gould:

All Medicare Admissions to [redacted] Medical Center are reviewed by the hospital's Utilization Review Department on the first working day following admission, as required by Law (S.S. Act, Title XI, Part B, Fed. Regs., Sec. 405.474, B1, iii, C1). Physicians serving on the Utilization Review Committee are concerned that each patient receives all the care needed and that the hospital's resources are used in the most effective and efficient manner.

Today it has been determined by the Utilization Review Committee, in conjunction with your attending physician, that your admission to the hospital did not require an acute level of care. Therefore, your stay cannot be certified as medically necessary for purposes of payment under the guidelines of the Medicare Program.

You may decide to remain in the hospital. However, alternate arrangements for payment will need to be made since your Medicare benefits will not cover you for this hospitalization.

If you disagree with this decision, you, or a representative, may request a reconsideration by sending a written request for reconsideration within sixty days of the date of this letter to Blue Cross of California, Medicare Division, P. O. Box 70000, Van Nuys, CA 91470, or the nearest Social Security Office.

Sincerely,

Utilization Review Committee

cc: Attending Physician- [redacted], M.D.
Patient Account Representative
Social Service
Blue Cross of California
Quality Assurance

Admission Denial

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11734 Wilshire Blvd. #111
Los Angeles, Ca. 90025
Nov. 14, 1984

Blue Cross of California
Medicare Division
PO Box 70000
Van Nuys, Ca. 91470

Ex. C

Patient Gould, Jack E.
Medical Record 14/194598
Admission Date. 11/6/84 - [redacted]
HIC # 276-03-0015A

Dear Sirs:

I appeal the decision of the Utilization Review Committee to deny the hospital admission on the above date as not medically necessary under guidelines of the Medicare Program. This decision is absolutely ridiculous and indicative that the Utilization Review Committee either did not recognize the facts or elected to ignore them. It is absolutely false to indicate that my attending physician was a party to the denial.

First, let me state that under the Freedom of Information Act, I request the names of the Medical Doctors who were a party to this decision and who took my care from my attending physician without my permission. This information is also required so that I may fully appraise the Television Media of this abhorrent situation at a press conference

I can only wish that the members of this Review Committee could experience the prolonged acute abdominal pain which caused me to go to the emergency, with my wife driving and me screaming in pain. On previous occasions, it had been necessary to inject pain relievers to alleviate the acute pain.

During my life time I have had six major abdominal surgeries, three of which were in 1983. (1) Four of these were emergencies, following acute attacks of

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Medical Record 14/194598

To Blue Cross of Cal From. Jack E. Gould

abdominal pain. Included were perforated duodenunal ulcers, abdominal aorta anyurism and peritonitis, ~~and~~ ruptured appendix and herniated appendix scar. In addition, with an unstable angina condition, right and left heart catherization have shown 3 ~~vessels~~ to have 75% or more blockage.

With this medical and surgical background, the blood tests ~~taken~~ in the Emergency Room showed elevated enzymes for the liver area. Oh yes, I did not mention that open heart surgery was being considered about 18 months ago, when a blood infection developed in an intensive care unit with suspicion first on the liver and later in the abdominal aorta graft. Heart damage had been observed in a previous hospital stay.

And you take the word of this Utilization Review Team? Since they have taken the responsibility for determining my level of care, they must also take responsibility for the payment of the hospital bill.

Copies of this letter are being sent to Senator Cranston, Congressman Beilenson and to Dr. Thorner.

I await the early reversal of the decision of the Utilization Review Board.

Very truly yours.

Jack E. Gould

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Medicare Program

Blue Cross of California

Federal Medicare Intermediary

P.O. Box 70000
Van Nuys, California 91470
(818) 703-2345

Date: December 6, 1984

Ex. D

Mr. Jack E Gould
11734 Wilshire Blvd. #C1110
Los Angeles, Ca. 90025

Beneficiary: JACK E GOULD
Health Insurance Number: 226-03-0015A
Provider Name and Number: [redacted]
Admission Date: 11-6-84

Dear Mr. Gould :

We have received your request for reconsideration of the services for which Medicare has disallowed payment.

Under the Medicare Program, the beneficiary has the right to a new and impartial review of any decision with which there is a disagreement. Blue Cross of Southern California, as Medicare intermediary, has been given the authority by the Social Security Administration to conduct this review and issue a determination to the beneficiary.

By copy of this letter, we are notifying the provider that is considered a party to the reconsideration and has the right to submit any additional information in this case prior to the determination. A copy of the Reconsideration Determination Notice will be sent when the review is completed.

Please keep this letter and the enclosed copy of Form HCFA-2649 for your own records.

Sincerely,

not received

Augustine J Bellon
Reconsideration Review
Beneficiary Services Unit
Medicare Claims Department

Enclosure

cc: [redacted]

4363 5/84

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Ex. E

CALIFORNIA MEDICAL REVIEW, INC.

District IV

18401 BURBANK BOULEVARD, SUITE 107, TARZANA, CA 91356

(818) 996-9891

Jack Gould
11734 Wilshire Blvd C 1110
Los Angeles Ca 90025

Date: March 4, 1985

I. CASE IDENTIFICATION

Patient Name: Jack Gould
Fiscal Intermediary: Blue Cross
Hospital: [redacted]
Admission Date: 11/6/84

HIC #: 376-03-0015A
Attending MD: [redacted]
Provider #: [redacted]
Disch. Date: 11/8/84

II. PHYSICIAN ADVISOR REVIEW DETERMINATION

__X__ Inpatient hospital admission not medically necessary.
_____ Procedure on _____ is denied.
_____ Other _____

_____ Reason for determination Hospital services provided on admission could have been performed on outpatient basis

Paid under waiver of liability? _____ Yes __X__ No

III. FEDERAL REQUIREMENTS

Review Authority: California Medical Review, Inc. (CMRI) has been designated by the U.S. Department of Health and Human Services as the Utilization and Quality Control Peer Review Organization for the State of California. Part of CMRI's review responsibility is to make determinations regarding the appropriateness of care rendered to Medicare patients.

Social Security Act: This action has been taken pursuant to Title XI.

Appeal Process: Even though this determination does not affect you financially, you, (or your representative), your physician or the hospital have a right to request a reconsideration. If you disagree with our decision and wish a re-review, please notify us in writing no later than 60 days from the date of this notice.

A request for reconsideration should be mailed to:

District Director
CMRI District IV - Tarzana Branch
18401 Burbank Boulevard, Suite 107
Tarzana, CA 91356

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Questions may be directed to the CMRI office at (818) 996-9891.

Ronald Laudwasi M.D./sl

cc: Hospital
Attending Physician
Fiscal Intermediary

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11734 Wilshire Bl. #[illegible]
Los Angeles Ca. 9[illegible]
March 9, 1985

District Director, CMRI District IV
Tarzana Branch, Suite 107
18401 Burbank Blvd.
Tarzana, Ca. 91356.

EXF

I CASE I.D. Patient - Jack Gould HIC # 276-03-00[illegible]
Fiscal Intermed - Blue Cross Provider #[redacted]
Hospital - [redacted] Physician [redacted]
Admission Date 11/6/84 Discharge Date [illegible]

Dear Sir,

I hereby request a reconsideration of [illegible] decision that the inpatient hospital admiss[illegible] was not medically necessary. Neither my attending physician ([redacted]) nor I agree with your decision.

In a telephone conversation, about Dec. 21, 1984 I was advised by Elaine Nichols, [redacted] Quality Assurance, that the denial letter of Nov. 7 (delivered to the hospital on Nov. 8) was sent to me in error and a letter of apology would be sent to me. Instead, the letter of March 4, 1985 was sent from your office. In the interim, I did receive a Medicare Benefit Notice, dated [illegible] from Fiscal Intermediary Blue Cross informing me that Medicare had paid for all services except for [illegible] deductible.

You either did not receive, or chose to disregard a copy of the letter of Nov. 14, 1984 which was sent to the Division of Blue Cross. The copy of that letter was sent to [redacted] Quality Control. It is simply incomprehensible to me that you could have denied the above in hospital after reading this letter. I am assuming that you did not see a copy and accordingly sending you a copy.

To discharge me from the Emergency Room, where I had been in acute abdominal pain for two hours and with complete knowledge of my history with acute abdominal pain (and an impending malpractice claim) would be tantamount to further malpractice.

I am fortunate to have an attending physician who places my immediate medical needs above ridiculous DRG regulations, which can materially affect mortality figures.

Very truly yours,
Jack E. Gould

Copy to: [redacted] Attorney at Law

CALIFORNIA MEDICAL REVIEW, INC.

PPS Reconsideration Determination Date: March 25, 1985

I. CASE IDENTIFICATION

Patient Name: Jack Gould
Fiscal Intermediary: Blue Cross
Hospital: [redacted]
Admission Date: 11-6-84
HIC #: 276-03-0015-A
Attending MD: [redacted]
Provider #: [redacted]
Discharge Date: 11-8-84

II. INITIAL ADVERSE DETERMINATION

XX Inpatient hospital admission on 11 / 6 / 84
____ Hospitalization on the following day(s): ____ / ____ / ____
____ Invasive procedure performed on ____ / ____ / ____
Reason for determination Hospital services provided on admission could have been performed on an outpatient basis.

III. RECONSIDERATION DETERMINATION

Request received from ____
Physician advisor reconsideration determination:
XX affirmed; ____modified; ____reversed the initial decision as follows:
XX Admission not approved.
____ Continued stay in the hospital is approved through ____.
____ Invasive procedure is ____.
Reason for determination After review of the medical record, and conversation with attending physician, the initial admission denial is upheld. Medical record documentation fails to support need for acute care hospitalization. Medical workup could have been effectively rendered on an outpatient basis following E.R. evaluation.

IV. FEDERAL REQUIREMENTS

Review authority: California Medical Review, Inc. (CMRI) has been designated by the U.S.Department of Health and Human Services as the Utilization and Quality Control Peer Review Organization for the State of California. Part of CMRI's review responsibility is to make determinations regarding the appropriateness of care rendered to Medicare patients.

Social Security Act: This action has been taken pursuant to Title XI.

Appeal Process: As a participant in the Medicare program you, the patient, have the right to a review of this reconsideration determination if dissatisfied with the decision and if this determination resulted in a charge to you for hospital services in excess of $100. This review will be performed by the Reconsideration Evaluation Section of the U.S. Department of Health and Human Services. If you desire such a review you may file a request with any Social Security Administration district office; or CMRI will help you file your appeal. Such an appeal must be filed within 60 days of the date of this letter. If you wish to file through the CMRI, please submit a written request to:
District Director, District IV
23848 Hawthorne Blvd., Suite 100, Torrance, CA 90505

Questions may be directed to the CMRI District Office at (213) 373-9151.

cc: R. Kaufman M.D., hospital, attending physician, fiscal intermediary.

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Ex. 84
(2)

DIPLOMATE OF THE
AMERICAN BOARD OF INTERNAL MEDICINE
AND CARDIOVASCULAR DISEASE

MEDICAL TOWERS
4535 WEST THIRD STREET • SUITE 480W
LOS ANGELES CALIFORNIA 90048
CARDIOVASCULAR DISEASES

TELEPHONE
(213) 859-3251

April 16,1985

California Medical Review Inc.
1375 Sutter St Suite 402
San Francisco, California 94109

RE: P.P.S.

Patient Name: Jack Gould
Fiscal Intermedeary: Blue Cross
Hospital: [redacted]
Admission Date: 11-6-84

H.I.C.: 276-03-0015A
Attending M.D.: [redacted]
Provider #: [redacted]
Discharge Date: 11-8-84

The above named was admitted on 11-6-84, in the Emergency Room with a two hour history of abdominal pain. The ER physician recommended hospital admission.

Patient previously had five major abdominal surgeries including removal of an abdominal aortic aneurysm. Because of possible intestinal obstruction, the patient was admitted to the hospital for observation and therapy.

The patient also has severe heart disease with an intra-cardiac pacemaker.

It would of been gross malpractice to have sent him home and not admitted him to the hospital at this time.

Sincerely,

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Suite C 1110
11734 Wilshire Blvd.
Los Angeles, Ca. 90025
April 20, 1985

Mr John L. O'Hara, Jr.
Associate Regional Administrator
Division of Program Operations
Region IX, HCFA - Dept. of Health & Human Services
100 Van Ness Ave
San Francisco, Ca. 94102

Re:- PPS - Reconsideration Determination
Fiscal Intermediary - Blue Cross Patient Jack L. Gould
Hospital - [redacted] M.C. H.I.C. - 276-03-0015 A
Admitted (from E.R) 11/6/84 Discharged 11/8/84
Total Charges $1556.50 — Payment Status: Medicare paid all covered services except $356.00 in-patient deductible (EOMB 1/4/85)

Dear Mr. O'Hara, —

I wish to request a review of the reconsideration denial by CMRI of the above hospital stay. I trust that you can forward this request to the Reconsideration Evaluation Section of HCFA (HHS). The following papers are included with this letter:
1) PPS Reconsideration (reply) dated 3/25/85, supporting initial admission denial.
2) Letter, dated 4/16/85 from attending M.D. [redacted] to CMRI affirming need for hospital admission.

(.)

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April 28, 1985

To John O'Shea, Jr.

From Jack Gould

3) Letter, dated 4/11/85, from Quality Control Assurance of [redacted] M.C. to me, apologizing for error in letter of 11/7/84.

4) Letter of 11/7/84, from [redacted] Hospital to me stating that the (CMRI) Review Committee, in conjunction with my attending physician, had determined that my hospital admission did not require an acute level of care.

I wish to add to the report of my attending doctor the following information. In September, 1983 following admission to UCLA Hospital I was subsequently placed in CCU after a myocardial infarction. The following month, while an in-patient at Cedars, the same thing occurred without rest.

Under the Freedom of Information Act, please send me any regulations or guidelines which may be available from MCM concerning hospital admissions under DRG and the various diagnosis for admission.

Very truly yours,
Jack E. Gould

(2)

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E+K

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES/HEALTH CARE FINANCING ADMINISTRATION

MEDICARE BENEFIT NOTICE

050625 DATE 01/04/85

JACK E GOULD
11734 WILSHIRE BL
C1110
LOS ANGELES CA 90025

HEALTH INSURANCE CLAIM NUMBER
276-03-0015A

Always use this number when writing about your claim

THIS IS NOT A BILL

This notice shows what benefits were used by you and the covered services not paid by Medicare for the period shown in item 1. See other side of this form for additional information which may apply to your claim.

1 SERVICES FURNISHED BY	DATE(S)	BENEFITS USED
[redacted] MEDICAL CENTER 8700 BEVERLY BLVD LOS ANGELES CA 90048	11/06/84 THRU 11/08/84	2 INPATIENT HOSPITAL DAYS

2 PAYMENT STATUS

MEDICARE PAID ALL COVERED SERVICES EXCEPT:
$356.00 FOR THE INPATIENT DEDUCTIBLE.

IF AUTOMOBILE OR LIABILITY INSURANCE, WORKERS' COMPENSATION OR, IN SOME CASES, A HEALTH PLAN FOR EMPLOYEES ALSO PAYS FOR THESE SERVICES, PLEASE CONTACT THE OFFICE BELOW ABOUT REQUIRED REFUNDS.

$ 1356.50 Total Charges

If you have any questions about this notice, call or write:

BLUE CROSS OF SOUTHERN CALIFORNIA
PO BOX 70000
VAN NUYS CALIFORNIA 91470
TELEPHONE NUMBER 1-213-703-3635

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EXPLANATION / GENERAL INFORMATION

A. **PAYMENT OF BENEFITS** — Payment for covered services was made on your behalf directly to the organization shown under **SERVICES FURNISHED BY** in item 1. Medicare paid for all services covered by the program except for items shown under **PAYMENT STATUS** in item 2. **YOUR MEDICARE HANDBOOK** tells you what hospital insurance pays for in a benefit period and what medical insurance pays for in each calendar year.

Hospital insurance covers inpatient hospital care, skilled nursing facility care and home health agency visits. Home health visits are also covered by Medicare under medical insurance, but the 2 benefits are handled separately.

Medicare medical insurance benefits for services you may have received from a physician or supplier are not ordinarily included on this record. If you have received physician or supplier services and the services are not mentioned under **PAYMENT STATUS** in item 2, a separate notice about these services is sent to you.

The number of covered days shown as used under **BENEFITS USED** in item 1 represent only those used within the billing dates under **DATE(S)**. If you received other covered services before or after the dates, separate notices about those benefits will be sent to you. A separate notice is sent each time payment for covered services is made on your behalf.

B. **SERVICES NOT PAID BY MEDICARE** — Medicare does not always pay the full cost of covered services in a benefit period. You are responsible for the specific deductible identified, if any, under **PAYMENT STATUS** in item 2 on the front of this notice. Deductibles must be met for each part of Medicare—hospital and medical insurance. A deductible applied to one part cannot be used to meet the requirements of the other. For a definition of "benefit period" and a detailed explanation of deductibles, see **YOUR MEDICARE HANDBOOK**.

Days still available in the benefit period or in the calendar year will not be paid for unless all Medicare requirements are met. The law does not cover all types and levels of institutional and home care. For a detailed explanation of Medicare requirements, see **YOUR MEDICARE HANDBOOK**.

Physicians's services are not covered by Medicare hospital insurance, but they are covered by Medicare medical insurance. If you have the medical insurance and receive services in a hospital from a physician, Medicare pays for 80% of the approved charges for these services (if you have met the required deductible). You are responsible for the remaining 20%.

Hospital insurance never pays for services such as TV or telephone and private duty nursing. The added cost of a private room can be paid only if medically necessary. Medicare insurance never pays for some services such as meals delivered to the home and full-time nursing care. **YOUR MEDICARE HANDBOOK** describes these non-covered items in more detail.

C. **OTHER HEALTH INSURANCE** — If you have other health insurance that pays for some or all services not paid for by Medicare, you may use this notice to claim the other insurance benefits. Since the insurance company may keep this notice, make a record or copy before sending it to them. If a breakdown of billing charges is needed, you may obtain it from the facility shown under **SERVICES FURNISHED BY** in item 1.

D. **YOUR RIGHT TO RECONSIDERATION OF THIS MEDICARE BENEFIT DETERMINATION** — If you believe that Medicare should have covered more of your expenses, please ask the office shown just below item 2 for an explanation.

You may also request a reconsideration or review of the decision. The request must be made not later than 60 days from the receipt of this record for hospital insurance expenses or not later than 6 months from the date of issuance of this notice for medical expenses. The date of issuance appears on the other side of this notice in the upper right hand portion just above your **HEALTH INSURANCE CLAIM NUMBER**. The request should be sent to the office shown below item 2. If you are not satisfied with the reconsideration or review, you may request a hearing which must be made not later than 60 days from the receipt of the notice of reconsideration for hospital insurance expenses or not later than 6 months from the date shown on a notice of review for medical expenses.

E. **FOR MORE INFORMATION** — If you have any questions not answered in **YOUR MEDICARE HANDBOOK**, please call or write the office shown below item 2. The people there will be glad to help you. If you write, be sure to include your **HEALTH INSURANCE CLAIM NUMBER** exactly as it appears on this record.

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(3)

[redacted] MEDICAL CENTER

Reply to:
Box [redacted]
Los Angeles, California [redacted]

Direct Dial Number

April 11, 1985

Jack Gould
11734 Wilshire Blvd #C1110
Los Angeles, Ca 90025

Dear Mr. Gould;

I am responding to a copy of a letter that you wrote to California Medical Review, Inc. (CMRI) regarding your denial of acute hospital care. We spoke in December regarding the denial letter of November 7th. At that time, I told you there was an error in the letter and an apology would be forthcoming. I apologize for the delay. The letter we gave you stated that your physician agreed with the decision and, in fact, he had not. We apologize for this error.

Under federal mandate we are required to review all patient records for level of care. In performing the utilization review process, when a patient's condition does not meet the acute level of care criteria, the case is discussed with the attending physician and one of the utilization review physicians. If the case remains questionable after their discussion, the case is referred to CMRI for review and a final determination. CMRI makes the final decision on all Medicare cases after an extensive review process. CMRI's determination on your case was that the care given to you could have been rendered at a lower level of care.

In cases where CMRI has issued a denial, we are mandated to notify the patient that Medicare will no longer reimburse the hospital after a certain date for inpatient services. The denial is not to say that a patient must leave the hospital but merely states Medicare will no longer pay for services and further costs will be the responsibility of the patient.

In your case, we notified you of CMRI's decision. In the reconsideration process CMRI upheld their decision. [redacted] Medical Center can make no further decisions regarding your case.

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Mrs. Lois Kipp, Director of Quality Assurance, has attempted to reach you on the phone but has been unsuccessful to date. If you have any additional questions please refer them to her at 213-[redacted].

I hope I have been of some assistance to you and I apologize for the delay in my response.

Sincerely,

Elaine Mickle, RN

Elaine Mickle, R.N.
Asst. Director Quality Assurance

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Ex. M.

REFER TO

OFFICE OF
HEARINGS AND APPEALS
Type of Claim: Hospital Insurance
SSN: 276-03-0015
11000 Wilshire Blvd.
Rm. 8200
Los Angeles,CA 90024

05-17-85
Jack E. Gould
11734 Wilshire Blvd.
Ste.C1110
Los Angeles,CA 90025

We have received your request for hearing. This office will notify you of the time and place of the hearing at least 10 days before the date of the hearing. You have indicated that you are not represented.

YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY OR OTHER REPRESENTATIVE OF YOUR CHOICE. A representative can help you obtain evidence, and can help you and your witnesses prepare for the hearing. Also, a representative can question witnesses and present statements in support of your claim. Experience has shown that representatives are very helpful at hearings. If you wish to be represented, you should obtain a representative as soon as possible so your representative may begin preparing your case. Please phone us, at the number shown below, if you decide to obtain a representative.

We are enclosing a list containing the names of organizations where you may be able to obtain a private attorney, a legal aid attorney, or a nonattorney to represent you. As indicated on the enclosed list, some private attorneys may be willing to represent you and not charge a fee unless your claim is allowed. Your representative must obtain approval from the Social Security Administration for any fee charged. Also, if you are not able to pay for representation and you believe you might qualify for free legal representation, the list contains names of organizations which may be able to help you.

If you have any evidence that was not previously submitted, please send it to this office immediately. If there is not enough time, bring the evidence to the hearing. Your social security office will help you in obtaining evidence, even if you have a representative. You will be able to see all the evidence in your file at the hearing. If you wish to see it sooner, please call my office at the following number (213) 209-7321.

$200

Have done

Sincerely yours,

MASTER DOCKET CLERK

[redacted]

Enclosure

Form HA-L41-U4 (9/79) (FORMERLY HA-L4.1)
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11000 Wilshire Blvd.
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(213) 209-7157 or 209-7780

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7966 Beverly Blvd. Ste. 210
Los Angeles, CA 90048
(213) 658-8930

SAN FERNANDO VALLEY
NEIGHBORHOOD LEGAL SERVICES
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Pacoima, CA 91331
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Los Angeles, CA 90014
(213) 972-0061

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(213) 487-3320

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OF THE DISABLED
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Los Angeles, CA 90006
(213) 731-8591

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Los Angeles,CA
(213) 381-2131

GRAY LAW
2936 West 8th St.
Los Angeles, CA 90005
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to
DPO-110

Region IX
100 Van Ness Avenue
San Francisco CA 94102
Tel.: (415)556-6566

APR 29 1985

Jack E. Gould
11734 Wilshire Boulevard
Suite C1110
Los Angeles, California 90025

Dear Mr. Gould:

This is in response to your letter of April 20, 1985 in which you requested a hearing on a reconsideration decision made by CMRI.

Your request and the additional documentation that you provided have been forwarded to the Reconsideration Evaulation Branch of HCFA so that a hearing can be set up. You will be contacted when the hearing date is established.

If I can be of any additional help, please contact me.

Sincerely,

Tom Burtscher, Chief
Beneficiary Services Branch

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Office of Hearings and Appeals

Name and Address of Claimant:

Ex. N

Jack E. Gould
11734 Wilshire Blvd. #C1110
Los Angeles, CA 90025

NOTICE OF DISMISSAL

PLEASE READ CAREFULLY

If you disagree with the enclosed order of dismissal, you have the right to request the Appeals Council to review it within 60 days after the date you received this notice. It will be presumed you received this notice within 5 days after the date shown below, unless you show us that you did not receive it within the 5-day period.

If you wish to request review, you (or your representative) should file the request at your local Social Security office. The people there will supply you with a request for review form and will be glad to assist you in completing the form. However, if you prefer, you may file your request for review at the hearing office or by sending a letter, requesting review, directly to the Appeals Council, Office of Hearings and Appeals, P.O. Box 2518, Washington, D.C. 20013.

This notice and enclosed copy of order of dismissal mailed

July 8, 1985

cc:
Name and Address of Representative

None

Form HA-L6021 UB (1-83)

CLAIMANT

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DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
Office of Hearings and Appeals

ORDER
OF
DISMISSAL

IN THE CASE OF:	CLAIM FOR:
JACK E. GOULD	Hospital Insurance Benefits
(Claimant)	[redacted]
	(Social Security Number)

The claimant requested a hearing on April 20, 1985 to review his claim for Medicare reimbursement for his inpatient stay at Cedars-Sinai Medical Center from November 6, 1984 through November 8, 1984.

According to 42 CFR 473.3, the procedures specified at 42 CFR 405.720, 405.722 and 405.740 govern hearings under section 1139(b) of the Act. This is the section under which the stay in question was reviewed and under which Mr. Gould requested the hearing. 42 CFR 405.720 states:

> A person has a right to a hearing regarding any initial determination made under Section 405.704 if:
>
> (a) Such initial determination has been reconsidered by the Health Care Financing Administration;
> (b) Such person was a party to the reconsidered determination;
> (c) Such person or his representative has filed a written request for a hearing in accordance with the procedure described in Section 405.722, and
> (d) The amount in controversy is $100 or more.

Mr. Gould received an initial determination from Cedars-Sinai on November 7, 1984 informing him that his admission did not require an acute level of care. On March 4, 1985, he was advised by California Medical Review, District IV, the Professional Standards Review Organization (PSRO) involved in this determination, that this determination did not affect the claimant financially.

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Mr. Mould further advised that he had a right to request a reconsideration.

He did request reconsideration and, on March 25, 1985, he was advised that the initial denial was upheld. He then requested a hearing in this matter.

It can be seen from the foregoing that Mr. Gould meets criteria (a), (b) and (c) of 42 CFR 405.720. However, since this was a retrospective review, the initial denial letter of March 4, 1985 pointed out to him that this determination did not affect him financially. His hospital statement of account confirms that Medicare did pay for this stay and that Mr. Gould's portion of the bill was limited to his Medicare deductible. The beneficiary acknowledged that Medicare had informed him that payment had been made for all services except for inpatient deductible. He did not incur any financial detriment as the result of these determinations.

Accordingly, since there is no amount in controversy, Mr. Gould does not meet criterion (a) of 42 CFR 405.720 and, through incorporation by reference, 42 CFR 473.3. He does not have a right to a hearing in this matter.

Pursuant to 20 CFR 404.957(c)(2) the request for hearing filed April 26, 1985 is herewith dismissed.

Leo J. Boehner

LEO J. BOEHNER
Administrative Law Judge

July 8, 1985
Date:

Form HA-514-C6 (10-83) CLAIMANT

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THE AFFILIATED COMMITTEES ON AGING OF LOS ANGELES COUNTY

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11734 Wilshire Blvd. # C 110
Los Angeles Ca 90025
January 7, 1986.

The Honorable Pete Wilson, Senator
1111 Santa Monica Blvd. #915
Los Angeles Ca 90025

Dear Mr. Wilson —

As an addendum to my testimony presented today at the Hearing of the Senate Special Committee on Aging in Los Angeles, I wish to add the following.

In reply to your last question to Dr. Wellesin Moncrief concerning increased hospital denials, he replied to the effect that fewer denials of admittance would result if admitting physicians would document a more comprehensive history of the patient. I held a brief discussion with Dr. Moncrief on this reply after the panel was excused. I pointed out that the admitting doctor, whose compensation for services under Part B of the Medicare program would not normally be approved for a comprehensive history and physical examination (RVS 90220-70 units). The hospital care for the initial visit (of a specific hospital stay) of an established patient would be at a level of intermediate or limited history (RVS 90215 or 90200-50 or 30 units). The reply made to me by Dr. Moncrief was that the complete history was in the doctor's head (pointing his finger to his temple) and should be written out. I replied "you know, doctor, that a doctor is not going to take the time to write this all down again when he will not receive the added compensation for this service."

Dr. Moncrief stated that he would correct his reply as he was not aware of this.

(1)

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RUTH GELBER

(2)

January 7, 1986.

This small incident may be an explanation or reason why there are so many cases of "anecdotal" denials of services.

I thank you again for the privelige and honor of permitting me to offer testimony for your Hearing. I trust that the information will be of help to the Special Committee on Aging in efforts toward delivery of Quality Care at minimum cost under the PPS Program.

Very sincerely yours,

Jack E. Gould

THE AFFILIATED COMMITTEES ON AGING IN LOS ANGELES COUNTY SERVE THE FOLLOWING COMMUNITIES:

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STATEMENT OF BARTLETT S. FLEMING, ASSOCIATE ADMINISTRATOR FOR MANAGEMENT AND SUPPORT SERVICES, HCFA, WASHINGTON, DC

Mr. FLEMING. I am pleased to be here representing HCFA and the administration to discuss an issue that we believe also is of the utmost importance, that is, the impact of the prospective payment system on the quality of care provided to our Medicare beneficiaries.

I have given you my complete testimony but I have a few summary remarks that I would like to make at this time.

First I want to emphasize that high-quality medical care has a longstanding tradition in this Nation, and despite pressures and efforts to "apply the brakes" on spiraling health care costs, I do not believe that tradition is in jeopardy. We certainly don't want it to be in jeopardy. We do not wish to remove the "care" from "Medicare."

What I believe we are seeing is a change in behavior, a revolution if you will, in the health care system—how services are delivered and how they are paid for. Virtually everyone in this society is involved in that process: The consumer, providers, and third-party payors as well. Consumers are becoming wiser shoppers, they have been brought into the marketplace, they have decisions to make. Corporations and unions are revamping benefit packages to contain costs. Insurance companies are changing their first-dollar coverage plans to include deductibles and coinsurance.

Many physicians are opting to provide services under salaried arrangements vis-a-vis fee-for-service arrangements. Hospitals are developing more cost-effective methods for providing services.

A prospective payment system is an integral part of the revolution. I think most would agree that the prospective system was an innovation in reimbursement methods whose time had come, and we expected and I believe we are realizing a number of positive effects from that change.

Let me emphasize that the complexity of the new payment system and its accompanying medical review requirements, presented an enormous challenge to the Department, and it is a challenge that has not ended and one which we still have to meet, day to day, and will for some time to come.

Let me emphasize that the most crucial objective throughout the payment reform process has been to maintain quality and access to care for our beneficiaries, a prime consideration.

To accomplish this, Congress mandated and we have implemented a strong, medical review mechanism known as the peer review organizations. Here in California we have contracted with California Medical Review, Inc. to perform those very important duties.

PRO's are required to perform very specific tasks under the prospective payment system which include the validation of DRG's, reviewing the completeness, adequacy, and quality of care and reviewing to assure appropriateness of admissions and discharge.

I might add that the California PRO has reviewed 35 percent of all discharges through September 1985, a total of about 249,000 cases since they began.

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I would like to speak briefly to some of the concerns we face this year and how we are addressing them. You share many of these concerns with us.

A major concern both of Congress and this administration has been the potential for premature discharge under PPS. You have heard some examples of these this morning.

We have heard, as has this committee, of anecdotal episodes of premature discharge. Where our investigation confirms that premature discharge has in fact occurred, we have taken and will continue to take immediate action, but I must stress that we are not seeing evidence indicating a systemic pattern of premature discharge, or other lapses in the quality of care provided to our beneficiaries.

For example, in California, the PRO's identified only about 368 possible cases of premature discharge, or incomplete care, out of 700,000 total discharges. This is about five one-hundredths of 1 percent.

Nevertheless, in our continuing effort to refine the PRO review system in the coming contract period, that is the new period of contract which we will bring the PRO's under this next year, we are expanding the review to further address the potential for premature discharge. PRO's will be required, for instance, to review all readmissions within 15 days of discharge rather than the 7 days as required under the current scope of work for the PRO's.

PRO's will be required to implement a generic quality screen to identify inadequate discharge planning.

PRO's will also continue to review transfers to another PPS hospital and to exempt units and swing beds to ensure that these transfers are appropriate.

As is currently required, in all cases where a PRO finds poor quality, corrective action must be taken. I would like to stress that we monitor the program very stringently and we take prompt action where we find deficiencies in the performance of the PRO's.

Another area which has concerned us is the continuing misunderstanding by some about PPS, PRO review, and the rights of patients to appeal. In addition to our own publication which explains beneficiary appeal rights, we have worked closed with the AARP—American Association of Retired Persons—to develop a publication on patients rights and will continue to work with similar groups.

In addition, we are including in the new PRO scope of work, a community outreach program to help beneficiaries understand the role of the PRO, and their appeal rights.

We recently informed the PRO's, through our regional offices, that PRO's must provide specific language to hospitals which the hospitals must use to inform beneficiaries of the existence of the PRO's, the fact that the PRO may review care provided and the right of the beneficiary to appeal a decision by the PRO with which he or she disagrees.

In addition to these efforts on a national basis, here in California, our regional office has undertaken further steps to assure that beneficiaries understand the prospective payment system, the role of the PRO and their appeal rights.

For example, informational communications addressing these issues have been sent to health care counselors, long-term care om-

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budsmen, senior centers, and county area agencies on aging, and detailed presentations have also been made to these groups as well as to others. Regional office staff have made appearances on radio, TV, and consumer talk shows to discuss the prospective payment system and quality issues.

We believe that an informed consumer can do more to protect his or her own rights than the Government really can, or any action by Government. We use every avenue available to us to assist our beneficiaries in becoming their own best advocates.

We hope that the media covering this hearing, will join with us in helping to educate the Medicare beneficiaries of their rights. We will not rest until we have made every effort to do that.

Now, I would like to briefly discuss posthospital care, specifically skilled nursing facilities and home health care, and how we monitor care provided in these settings. I know this is of concern to you and to a number of others, but note that we are not seeing a significant increase in hospital discharges to either the skilled nursing facilities or to home health agencies.

Skilled nursing facilities and home health agency benefits are important components of the Medicare Program providing coverage of post acute care when hospital care is no longer appropriate.

Quality assurance for skilled nursing facilities and home health agencies is accomplished through the survey and certification process which involves periodic inspection by State agency health professionals.

In anticipation of unique incentives under PPS, we recently modified this process to focus more closely on patient outcome. The modified survey process for skilled nursing facilities is being tested on a limited basis in each State and focuses on the patient, what are the patient's needs, have the services been ordered by the physician to meet those needs, and are the services being delivered as the physician has directed.

Medical review of admissions to skilled nursing facilities by fiscal intermediaries has also been strengthened in order to assure that Medicare beneficiaries are not inappropriately admitted.

In addition, we expect in the very near future to require the State survey agencies to begin home visits to review care being received by home health care patients.

We believe these measures will continue to ensure the provision of quality of care in these settings.

We are also conducting research and demonstrations to test new delivery and financing systems to enhance payment reforms while assuring that necessary quality care is available to our beneficiaries. For example, we believe that capitation has terrific potential to achieve these objectives. Capitated health care programs have a distinct advantage of including more local decisionmaking in the structuring plans, providing additional benefits and delivering care more effectively.

We are seeing a strong, positive response to health maintenance organizations. In California we have contracted with 12 HMO's to provide care under arrangements that are attractive to both providers and beneficiaries.

We are also studying capitated programs called social HMO's which provide consolidated health and social services, including

case management in a delivery system organized to provide comprehensive health and community based long-term care benefits. One such program is now in operation, I believe, in Long Beach.

Other areas of study include a comprehensive effort to reform payments to physicians, alternative pay methodologies for posthospital services provided by skilled nursing facilities and home health agencies, and demonstrations which fulfill the long-term care needs of the elderly through a community based system of care assessment and planning management.

PPS is unique, it is an innovative program, we believe it is working but we are not sitting still. While continuing to improve the system for hospitals, we are moving to other areas that I have outlined.

In conclusion, let me simply say that we are extremely pleased with the progress of PPS and the performance of the PRO's in assuring that high quality care is maintained. This success is shared by providers and physicians whose efforts have contributed significantly to the smooth implementation of the program. I assure you we are not sitting still and there is yet work to be done.

I will be happy to answer any questions that you have at the appropriate time.

Senator WILSON. Thank you very much, Mr. Fleming.

[The prepared statement of Mr. Fleming follows:]

PREPARED STATEMENT OF BARTLETT S. FLEMING

INTRODUCTION

Mr. Chairman, I am pleased to be here today to discuss an issue of the utmost importance; the impact of the Prospective Payment System (PPS) on the quality of care provided to Medicare beneficiaries. We share your interest in assuring that the prospective payment system is achieving its goal of providing medically necessary and appropriate care for our beneficiaries in a cost effective manner.

HEALTH CARE REVOLUTION

High quality medical care has a long-standing tradition in this nation. Today, the challenge is cost, and despite the pressures and the efforts to "apply the brakes" on spiraling health care costs, I do not believe that tradition is in jeopardy.

What I believe we are seeing is a change in behavior, a revolution if you will, in the health care system—how services are delivered and how they are paid for. And everyone is involved; consumer, providers and third party payors alike. Consumers of health care services are becoming wise shoppers, spending their health care dollar where they receive the most benefits; corporations and unions are revamping benefit packages to contain costs through use of HMOs, second surgical opinion programs and expert panels to review and predetermine what services will be covered and at what level of reimbursement. Insurance companies are changing their first dollar coverage plans to include deductibles and coinsurance. And, they are advertising flexible benefit plans tailored to minimize premium costs.

We are also seeing fundamental changes in how health services are being delivered. More physicians are opting to provide services under salaried arrangements through their involvement in HMOs and group practices rather than under the traditional fee for service mechanism. Physicians are becoming more aware of the costs of health care services and technologies they order for patients and are being asked to make judgments on the necessity of services. Changes are being seen in hospitals as they develop more cost effective methods for providing services and especially services involving high technology procedures. There is also evidence of a decrease in ancillary services with hospitals moving away from the overutilization of services and the duplication of equipment that prevailed in the past. There is an increased sharing of services between providers, increased specialization of cases within those hospitals which are best equipped to handle them, and greater competition among hospitals.

All of these events, and more are happening now within this nation's health care system.

PROSPECTIVE PAYMENT SYSTEM

An integral part of this dynamic revolution is the prospective payment system. There are few who would not agree that the prospective payment system (PPS) is an innovation in reimbursement methods whose time had come.

For over 17 years, hospitals were reimbursed by Medicare on a reasonable cost basis which failed to encourage efficiency since we reimbursed basically whatever costs were incurred. Under PPS, hospitals are provided a known payment—set in advance—that is based on the patient's diagnosis. There are a number of positive effects which result from a perspective system:

Patients are protected from incidents of unnecessary hospitalization, unnecessary surgical intervention; and unwarranted extended hospital stays;

Hospitals are rewarded for careful utilization of resources, as the system encourages management to organize and provide services in an efficient and cost-effective manner;

The system ensures greater predictability of revenue for the hospital; and

The role of the Federal Government as a prudent buyer of services is reinforced.

And the system is working well. We are seeing a decrease in overall Medicare short stay hospital admissions and a decrease in the average length of stay. Early data indicates that physicians are reducing ancillary services and encouraging outpatient testing. And yet, hospitals are still enjoying a comfortable profit margin.

Let me emphasize that the complexity of the new payment system and its accompanying medical review requirement presented an enormous challenge to our Department. Although implementation of PPS is moving into the third year of transition to a national rate and the Peer Review Organization (PRO) program is fully operational, that challenge has not ended.

To meet the demands of the constantly changing health care marketplace, we are continuing our ongoing activities to refine the prospective payment system to ensure that payment levels support delivery of quality care. It is also important to assure that reimbursement levels appropriately reflect labor costs which represent approximately 80 percent of a hospitals revenue. We have developed and plan to use a modified wage index to adjust the labor portion of the DRG rates. We are also studying other refinements such as adjusting the rates to account for severity of illness, and consequently are involved in a comprehensive research effort to determine how to recognize differences in severity among patients with similar diagnoses. We are also investigating how to deal equitably with rural hospitals which compete with closely neighboring hospitals in urban areas. And, we have undertaken an extensive research effort to enable us to define and address the issue of hospitals which serve a disproportionate share of low income and Medicare patients.

Concurrent with the positive changes PPS is achieving there also exists, within the system, incentives for providers which could impact on the quality assurance of patient care. It is on this issue—quality of patient care that I'd like to focus today.

QUALITY OF CARE

The most crucial objective throughout the payment reform process has been to maintain quality and access to care for our beneficiaries. To accomplish this, Congress enacted a strong, medical review mechanism. The Peer Review Organizations (PRO) amendments of 1982 put this mechanism in place and the Administration has implemented it with vigor. In general, PROs are charged with the tasks of assuring quality of care and reducing unnecessary utilization of inpatient services. They are required to perform specific tasks under the prospective payment system which include: validation of DRGs, reviewing the completeness, adequacy and quality of care and reviewing to assure appropriateness of admissions and discharge. I might add, Mr. Chairman, that in this report review, California Medical Review, the California PRO, has reviewed 35 percent of all discharges through September of 1985, for a total of about 249,851 cases since they began review.

Let me emphasize here, Mr. Chairman, that this is a unique time in our pursuit of quality care for Medicare's beneficiaries. We know more about quality assurance now than we did under the cost reimbursement system. We are collecting more data and we are spending more time and money on quality assurance than at any other time in the history of the Medicare program. We believe that PROs will continue to ensure that quality medical care is delivered in this country's hospitals and that payments continue to be appropriate.

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PROPOSED PRO SCOPE OF WORK

Just as PPS is a new system necessitating adjustments as it progresses, PROs will change to conform with these adjustments.

The PRO's proposed scope of work for the coming contract period addresses many of the concerns we've faced this year. I would like to speak to these briefly.

A major concern both of Congress and the Administration has been the potential for premature discharge under PPS. Under the current scope of work PROs are required to review all cases of readmission to a hospital within seven days of a discharge to determine if the readmission is a result of inappropriate care or premature discharge on the first admission. And PROs have been directed to deny payment to the hospital for a second admission to that hospital when that readmission is determined to be the result of inappropriate care or premature discharge.

Although data indicate that a systemic problem does not exist, we have heard, as has this Committee, anecdotal episodes of premature discharge. These episodes are traumatic to the individuals involved and totally unacceptable to this Administration. While it is unrealistic to expect that we can eliminate all such instances of poor quality of care, when we learn of them, we will take immediate action and we are using this anecdotal information to further refine PRO review. But these anecdotal cases should not obscure the big picture. Of the 716, 534 PPS discharges in California for example, the PRO identified to date, 368 possible cases of premature discharge or incomplete care. This represents one half of one percent of the total California PPS discharges. California Medical Review is vigorously pursuing each and every potential case of quality abuse and initiating sanction actions when appropriate.

California Medical Review's commitment to quality is evidenced by their response to our request to conduct a pilot study on premature discharge. Under this study, they will expand their present review activities to include hospital readmissions which occur between eight and 21 days of discharge and hospitalizations in which patients die within 20 days of discharge.

In the coming contract period for all PROs, the proposed scope of work would expand PROs ability to prevent premature discharge in the following ways:

PROs will be required to review all readmissions within 15 days (instead of the current 7 days) of discharge;

PROs will be required to implement generic quality screens to identify inadequate discharge planning, other quality issues and to take corrective action.

PROs will also continue to review transfers to another PPS hospital, exempt units and swing beds to ensure that these transfers are appropriate.

As is currently required, in all cases where a PRO finds poor quality, corrective action must be taken, ranging from education of the individual physician or hospital, to intensified review, to payment denials where actions are taken to circumvent PPS, and ultimately to exclusion from the Medicare program.

Let me say here, Mr. Chairman, that the California Medical Review has made a concentrated effort to educate and involve physicians, Medicare beneficiaries and hospitals in the PRO program. To achieve this objective, they recently appointed two Medicare beneficiaries and two hospital administrators to their previously all physician board of directors. This kind of commitment and cooperation goes far in assuring the best possible quality of care for Medicare beneficiaries.

PATIENT'S RIGHTS

Another area that has concerned us is the continuing misunderstanding by some about PPS, PRO review, and the rights of patients to an appeal where payment for care is denied. We believe part of this problem is related to beneficiaries not clearly understanding the entire PPS process, although we have worked to our utmost to assure their full awareness. Several HCFA publications explain beneficiary's appeal rights. In addition, HCFA worked closely with the American Association of Retired Persons (AARP) to develop a publication on patient's rights under PPS.

Here in California, our San Francisco Regional Office has taken additional steps to assure beneficiaries understand the prospective payment system, the role of the PRO and their rights of appeal. Informational communications addressing these issues have been sent to health care counselors, long-term care ombudsmen, senior centers and county area agencies on aging; and numerous detailed presentations have been made to these groups and others. Further, regional office staff have made appearances on radio and TV consumer talk shows to discuss the prospective payment system and quality issues.

In addition to these efforts, hospitals are required to inform patients of the purpose of PRO review and their rights of appeal. Anecdotal information indicates that

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this is not always happening. We are currently developing plans to assure that beneficiaries are informed of their rights while in the hospital. We recently informed PROs, through our regional offices, that they must provide specific language to hospitals which the hospitals must use to inform beneficiaries, upon admission, of the existence of the PROs, the fact that the PRO may review care provided, and the right of the beneficiary to appeal a denial notice from the hospital and decision by the PRO with which he disagrees.

We believe that an informed consumer can do more to protect his or her own rights and to influence the efficiency of the health care system than any government action. We will use every avenue available to us to assist our beneficiaries in becoming their own best advocate. And, we hope that the media covering this hearing will join with us in educating Medicare beneficiaries of their rights. We certainly will not rest until every effort has been made to do so.

MONITORING OF PRO PERFORMANCE

In addition to making refinements in PPS and PRO review, we are closely monitoring what PPS and PRO review actually means to the Medicare patient. We want to know, for instance, how PROs are functioning to assure quality of care for Medicare beneficiaries. One way we are doing this is through the SuperPRO. The SuperPRO is an organization of health care professionals whose reports will provide us with an unbiased evaluation of PRO performance, e.g., is the PRO making correct determinations regarding a patient's admission and need for continued stay, is the PRO conducting its review properly? We have already started to receive reports from the SuperPRO and expect to have at least one final report on all 54 PROs by the end of March 1, 1986.

I would like to stress that we monitor the PRO program very stringently and take prompt action, including termination, where we find deficiencies in performance.

In addition to the functions of PROs and the SuperPRO and what they tell us about the impact of PPS on Medicare beneficiaries, we are independently looking at this impact on patient care through five separate quality of care evaluations; four of which will be completed under contract with health care research firms. These studies are:

to detect broad PPS related effects on quality of care by examining the outcomes of hospital care on the health status of patients;

to measure the general effects of PPS on the quality of inpatient hospital care primarily by examining changes in hospital usage and treatment patterns, and their effects on inpatient and discharge status;

to evaluate the impact of PPS on the quality of care by assessing potential effects on changes in inpatient hospital treatment patterns through a thorough examination of the medical record, and resultant health status outcomes; and

to investigate the feasibility of using Medicare (nonintrusive outcome) administrative data to detect quality of care levels within individual hospitals; and

to evaluate PPS quality impacts on ESRD Medicare beneficiaries, a subset of the Medicare population generally assumed to represent an unusually high medical risk group.

We expect that each of these studies will provide further information on: where PPS is working well; how it needs to be changed to work better; and how PRO review should be refined.

MONITORING—SURVEY AND CERTIFICATION

Our concern for access and quality, however, extends beyond PRO hospital review. We have a number of measures in place that further underscore our commitment to maintaining the highest possible level of quality care. The survey and certification program protects the health and safety of beneficiaries in Medicare facilities, such as hospitals and skilled nursing facilities (SNFs); and of beneficiaries who receive home care through a certified home health agency.

States accomplish this survey function for the Medicare program. Through cooperative efforts with the Joint Commission on the Accreditation of Hospitals and the State Survey and Certification Agencies, this program works to uphold the standards and conditions for participating in the Medicare program. In this process, we have found that hospitals are not compromising their standards of care.

In anticipation of the unique incentives under PPS, we recently modified the survey process for SNFs and HHAs, to focus more closely on patient outcome. The modified survey process for SNFs, currently being tested on a limited basis in each State, focuses on the patient—what are the patient's needs, have services been or-

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dered by the physician to meet those needs, and are the services being delivered as ordered.

In addition, we expect, in the near future, to require State survey agencies to begin home visits to determine the efficacy of care delivered to our beneficiaries in the home setting. The coverage compliance review program for HHAs has been strengthened by instituting similar visits by intermediaries into the homes of a sample of beneficiaries to assure provision of appropriate care.

Medical review of admissions to SNFs by fiscal intermediaries has also been strengthened in order to assure that Medicare beneficiaries are not inappropriately admitted to SNFs. The intermediaries have been working closely with providers to assure that there is a clear understanding of applicable coverage criteria. Additionally, fiscal intermediaries and carriers are evaluated to assure that medical review determinations are accurate and are in conformance with HCFA guidelines and instructions. These checks protect older Americans from inaccurate determinations by the intermediary.

We believe that these Medicare benefits are being administered in a manner wholly consistent with the intent of Congress, both in the statutory language and in the legislative history of the benefits. Our payment experience has been consistent and there has been no reduction of coverage. We believe that the operation of PPS will increase the likelihood that patients, will receive post-hospital services at a point in their recovery where that care is appropriate. We will continue to monitor trends in SNF and home health care utilization in order to assure that this is the case.

CONCLUSION

In conclusion, let me say that we are extremely pleased with the progress of the prospective payment system and the performance of peer review organizations in assuring that high quality care is maintained. This success is shared by providers, and physicians whose efforts contributed significantly to the smooth implementation of the program. As with any innovative program, no matter how well thought out, there are always wrinkles to iron out. The effects of PPS on quality of care will continue to emerge over time. Where these effects have a negative impact, we will move swiftly to correct them as we have in the past.

Responsibility to ensure quality of care, however, does not rest solely with the government. It is a responsibility which must be shared with the physicians, other providers and consumers. We look forward to continued cooperation in our shared goal of ensuring that every patient receives high quality, medically necessary care. I will be happy to answer any questions you may have.

Senator WILSON. Dr. Moncrief.

STATEMENT OF DR. WILLIAM H. MONCRIEF, JR., M.D., PRESIDENT, CALIFORNIA MEDICAL REVIEW, INC., SAN FRANCISCO, CA

Dr. MONCRIEF. Senator Wilson, my name is Dr. William H. Moncrief, Jr., and I am a practicing thoracic and vascular surgeon in San Francisco and president of California Medical Review, Inc.

One of the advantages of being last on the panel is that my oral remarks can be quite brief because I certainly concur in most if not all of the comments that Eva Skinner, Jack Gould, and Mr. Fleming have presented to you.

I would briefly like to emphasize a couple of points though. California Medical Review is the largest PRO in the country and oversees the inhospital medical care of 2.8 million beneficiaries in California, has been quite busy the last year. There are several points that have really surfaced in this last year of review, and there is no doubt in my mind that the PPS system in some ways has improved quality of care, but there are certainly anecdotal situations where quality of care has been compromised on the basis of fiscal incentive.

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The potential for premature discharge is real. There is no question about that. Eva Skinner has mentioned several such cases. The need for proper planning; the policy of the PPS system is good. It was implemented rapidly, but when the policy was established, little thought, at least to me, in the way we have seen it implemented in California, was given to post-acute hospital care planning. There is no question about that.

There is a great need and a continuing need for education of the beneficiary. We are all working hard in this regard, but it is awfully difficult to get across an idea of appeal rights, what do you do and everything else when you are in an admitting office of a hospital. It has to be done before the patient gets to the hospital.

The PRO's have a responsibility and HCFA is seeing to it that we implement the responsibility of the hospitals notifying the beneficiaries of their rights on admission to the hospital. This is too late. Ask Jack Gould when he checks into a hospital. Ask Eva Skinner when she comes to the hospital. There are too many things going on in that admission office for the beneficiary's rights and the system of appeal and everything else to be explained to him in the admitting office. It has to be done daily, monthly, frequently, and I will address that a little later.

During the past year we have identified quality of care issues and we have addressed literally hundreds of quality of care issues, a whole spectrum of quality of care. We have moved aggressively in some of these areas. I would like to emphasize that poor quality can only be identified by a physician. It is physician judgment that says that is poor quality. Historically, practicing physicians have been reluctant to get involved in quality of care issues. It interferes with referral patterns; it takes time away from practice. CMRI is a physician membership organization, and as such affords the practicing physician, the physician community, an opportunity to do arm's-length quality review which is what we need.

There is no doubt that a few hospitals are compromising care in the name of DRG. With the testimony that has been submitted to your committee is a recent letter from the husband of a Medicare beneficiary. Briefly it is a patient who was to be admitted for elective parathyroid surgery, and the husband and the patient both requested the patient be admitted the day before. The hospital told the patient and her husband that it was impossible, that she was scheduled for early a.m. surgery; she would have to be admitted at 5 o'clock in the morning—it was a 2-hour drive. That meant this elderly patient had to get up at 3 o'clock in the morning to drive to the hospital to be admitted at 5 o'clock for a 7:45 case. The husband even asked the hospital if he could pay for the preoperative day and they were told, "No." This was on the basis that Medicare would not pay for it. This is silly. Now, CMRI and every PRO in the country has a preadmission certification program, but that is for: One, should the procedure be done; and, two, does it have to be done on an inpatient basis.

This particular surgical procedure does not require preadmission certification at all, but in those cases where the PRO, in this case CMRI, does certify the admissions, the number of preoperative days for the patient to be in the hospital is not a CMRI concern. Quite frankly we could care less if the patient stays in the hospital

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1 week before surgery. This is up to the institution, the hospital administration, and the medical staff, to make this decision. It really gets under my skin a little bit to have hospitals tell patients that Medicare won't pay for it, or Medicare says your day is up or the DRG has run out. To me this reflects on the physician community considerably because the doctor should be the patient's advocate, he should stand up to the institutional system that says your patient has to get out of the hospital. I can certainly appreciate Jack Gould's comments when his 2-day admission was denied and his physician appealed it, and the denial was overturned.

Regarding the premature discharge issue, there are two points. One is the perception of the beneficiary. Historically in the cost-reimbursement system, the beneficiaries were allowed to stay in the hospital until they felt they could go home and take care of themselves, or the family could take care of them.

The PPS system and I think properly so, has shortened the length of the acute hospital stay, but it is the patient and the physician's responsibility, the patient's family responsibility, to plan for post-acute hospital stay.

I and the CMRI staff encourage the beneficiaries to ask questions: "What is it going to be like when I leave the hospital? What will I need, how long will I stay, what sort of help will I need?" Most of these situations arise in elective surgery. There is plenty of time to plan, and if you don't like the answers, I repeatedly tell the beneficiaries, if you don't like the way your attending physician answers your questions, ask another doctor. Don't hesitate.

At the present time--and I support Mr. Fleming's comments wholeheartedly—we don't have any hard data that says there is a pattern of premature discharges. Most of them are anecdotal today. There are some organizations where it appears to be a corporate policy to keep the hospital stay as short as possible.

I personally know of some institutions where discharge planners are paid a base salary and then are paid on a commission basis vis-a-vis the DRG's—the dollars that they save—the hospital. But there are all sorts of games that are being played, but that is the way of American society today, it is gamesmanship. But unfortunately the Medicare beneficiary is penalized in some of these games.

We have an extensive program of education to the Medicare beneficiary. In addition, in the premature discharge area, CMRI is one of eight PRO's that have a investigative contract to take a look at the question of whether there are premature discharges and the impact of such premature discharges. We are going to look at all cases that have been readmitted within 20 days of being discharged, and we are going to look at all deaths within 20 days of discharge from the hospital in three areas of the State—San Francisco, Los Angeles, and Kern County. To review the clinical records: One, to see if there was proper discharge planning; and, two, if the discharge was premature, did it bring about a mortality or excessive morbidity on the part of the patient. That will be 1 year's research effort and hopefully it will be completed by the end of 1986.

I can appreciate Mr. Fleming's comments on the review of home health agency care and skilled nursing facility care, but the fact remains that problems are there.

There is an old adage in the practice of medicine, "That you are not remembered for the patients you save, but you are remembered for the ones you lose."

While the program is good, the review program is good, there are enough anecdotal cases that occur, that there obviously have to be problems.

The PRO's in the United States have repeatedly for the past year, asked HCFA to let us get involved in post-acute hospital quality review. It is expensive and I can understand the budgetary constraints, but there are enough problems there, there is enough smoke in this area that I think it deserves additional funding.

One last point that has caused quite a bit of concern to me, personally and to the organization, is the care of the terminally ill. We see increasing emphasis in this society in which we practice and deliver health care, particularly in nursing homes and custodial care facilities, the terminal care patient being transferred from the nursing home or the custodial care facility to the acute hospital emergency room. Once in the hospital ER, the institution, the hospital, the attending physician is obligated to admit the patient.

It is not a "dump"; it is a question that the nursing home doesn't want to get involved in the death sequence. I think it is unfortunate.

But in any event, the patient is admitted to the hospital, the attending physician in consonance with the wishes of the family, the next of kin, the first order written in the chart is "No Code." That means do not resuscitate in the event of cardiopulmonary arrest. And the next order will be morphine, or some type of analgesic, every 3 or 4 hours. There is a minimal admission note and the patient expires within 24 to 36 hours, as expected. But CMRI, the PRO, looks at that clinical record. Three months later, or 4 months later, and there is nothing in that clinical record documentation that says why the care that patient received in the hospital, couldn't have been delivered in the nursing home. We are obligated to deny that admission. That's the way the rules of the game are written. We are obligated to. We are being audited by the GAO, the IG, HCFA, the super PRO, and if we don't play by the rules of the game, we are going to be out of business.

Now, something has to be done to take care of the terminally ill, whether it is a terminally ill DRG, whether we waive the 3-day acute hospital stay before SNF placement; we are working hard on physician education in this regard. To have the physician adequately document the need for acute hospital level of care.

Another point that comes up is the terminal patient has been in the hospital for a couple of weeks. In discussion with the family a "No Code" order is written, and then we find the attending physician, writing no progress notes, nothing, until a death note 5 or 6 or 7 days later. We are obligated under the rules of the game to deny acute hospital stay, hospital reimbursement for those last 5, 6, 7 days later.

We see this mostly in the small community hospitals. We don't see it in the tertiary referral centers where there are residents that

have an obligation to write a progress note every day; where the social workers or discharge planners, document the need for the patient to stay. It is an educational process that we have implemented in the physician community.

But for the acute admission, the terminally ill patient, I think there is a strong need for some type of a terminal illness admission DRG that will justify this.

The question posed to the American society is where will the terminally ill be cared for and at what cost.

One of the things that the PRO's need across the country is expansion of quality review. I appreciate HCFA's problem, but as we get into the quality issues this is a much more expensive review. Utilization review of the patient being in the hospital is a relatively inexpensive program. But when you get into quality review, issues where the definition of "quality" depends on physician judgment, you are getting into an expensive program. Particularly qualify review in the post-acute hospital setting, we are going to need additional funding; there is no question about that. I recognize the national budget constraints but if this is an important enough problem, we have got to have the dollars to do it.

Quality issues must be solved as they arise. They can't be put off for years. We in California are taking prompt action, as prompt as we can. The sanction process is a long drawn out one, emphasizing due process for both the provider and the practitioner, but they must be acted upon promptly.

Senator Wilson, I thank you for this opportunity, and any questions that you might have, I will be more than pleased to answer.

[The prepared statement of Dr. William Moncrief, with attachments, follows:]

PREPARED STATEMENT OF WILLIAM H. MONCRIEF, JR., M.D.

EXECUTIVE SUMMARY

As Medicare's largest Peer Review Organization (PRO) in the nation, California Medical Review, Inc. (CMRI), serves as the patient advocate for the state's 2.3 million Medicare beneficiaries and shares their concerns, along with Senator Wilson's, for access to quality health care.

The key issues addressed in testimony submitted by CMRI include:

Preserving quality of care in a cost-containment environment.

Avoidance of premature discharges.

Proper planning for post-acute hospital care.

Adequate education of Medicare beneficiaries regarding Medicare's Prospective Payment System (PPS) and their rights within the system.

Care for the terminally ill.

It is the responsibility of each PRO to emphasize the quality of care provided to Medicare beneficiaries and to identify for the federal government areas of concern where only federal intervention can correct or prevent shortcomings as a result of the PPS.

The PROs and the Health Care Financing Administration must work together to assure that beneficiaries understand their health care rights under Medicare and receive quality care in the appropriate setting. To fulfill the latter, PRO review must be expanded beyond the acute care facility and the Department of Health and Human Services must work diligently to assure that PROs have adequate funds to conduct quality review and to sanction hospitals and physicians providing inferior or substandard care.

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INTRODUCTION

Senator Wilson, my name is Dr. William H. Moncrief, Jr. I am a practicing thoracic and vascular surgeon in San Francisco and President of California Medical Review, Inc., the state's Medicare Peer Review Organization.

California Medical Review, more commonly known as CMRI, is recognized as a leader among PROs nationwide. As the largest PRO in the country, CMRI reviews acute-hospital care provided to 2.3 million Medicare beneficiaries and is well known for its aggressive action in quality care issues.

We share your concern with the effect Medicare's Prospective Payment System and other sweeping cost-containment measures in our nation's health care system are having on health care quality for the nation's senior citizens.

I am here today to describe some of CMRI's concerns; some related directly to the Prospective Payment System (PPS) and some associated with implementing the system. Directly related to the PPS and of major concern to CMRI is the: quality of care received by beneficiaries in an environment that provides hospitals with a prime incentive to save dollars, potential for premature discharge which I define as release of patients from an acute-care facility medically unstable for the environment to which they are discharged, and proper planning for post-acute hospital care.

Two issues related to the needs of beneficiaries and of equal concern to CMRI are the: level of beneficiary education regarding PPS and patient rights under the system, and care of the terminally ill, a long-standing but little addressed issue that is attracting increasing attention due to confusion over the appropriate level of care needed.

I think it is most important that this committee hear the issues and, where necessary, prepare remedial legislation to address the potential negative outcomes associated with cost-containment efforts.

Medicare is not alone in its interest to curb soaring health care costs. Health insurers and employers in the private sector also recognize the need for cost-effective health care and are implementing a variety of self-designed or purchased programs toward this objective. The thrust to reduce health care costs has produced a profound shift in care from acute-care hospitals to alternative health care settings. The issues of concern to Medicare beneficiaries today will be issues of concern to all health care consumers tomorrow. That is why our emphasis today on quality of care under Medicare's Prospective Payment System is so important.

Although CMRI has made great strides in assuring quality and appropriate health care under our federal mandate, Medicare's Prospective Payment System and PRO program have identified serious gaps in the health care system that are resulting in diminished quality care.

INCENTIVES AND QUALITY CARE

The Prospective Payment System has dramatically changed the incentives for hospitals treating Medicare patients. Hospitals now have financial incentives to perform fewer services and to discharge Medicare patients from hospitals as soon as possible.

I would like to discuss CMRI's experience during the past year with quality care issues stemming from these hospital incentives and to recommend actions to assure that these incentives and other aspects of the cost-reduction system do not undermine quality health care in California.

As you may know, CMRI's primary concern is to see that hospital cost-containment incentives do not result in compromised quality care. Since CMRI began operation in October, 1984, our organization has addressed hundreds of quality of care problems by working with physicians and hospitals to change poor quality practices identified through our review activities. I have been amazed to find quality problems ignored by hospitals until CMRI intervened.

CMRI has not hesitated to take serious action against hospitals and physicians that have violated quality care standards in a gross and flagrant or consistently substandard manner.

Currently, pending before the Office of the Inspector General, we have four sanctions against physicians and hospitals that could result in their removal from the Medicare program or require them to repay a patient's health care costs. We are also currently investigating more sanctionable cases and may recommend as many as 100 sanctions by the end of 1986.

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HOSPITAL-IMPOSED LIMITATIONS

Although most hospitals have become more cost-effective while maintaining quality, other hospitals are compromising care in the name of DRGs.

For instance, the letter included in your packets today is typical of complaints we receive from beneficiaries. The letter outlines a hospital's refusal to admit a patient saying that Medicare would not permit the admission the day before surgery. Instead, the patient was expected to get up at 3 a.m. to be admitted to the hospital at 5 a.m. for a five-and-a-half hour operation that same day. This incident is an example of hospital-imposed limitations. We hear again and again tales of hospitals and physicians erroneously telling Medicare patients that their DRG days have run out or Medicare demands they leave the hospital.

CMRI is alert to hospitals' responses to financial incentives in our review. We review each case from the perspective of each patient's specific needs. In our preadmission certification program for elective surgery, we authorize reimbursement to hospitals for admissions on the basis of medical necessity without imposing limitations on days of care or services provided.

PREMATURE DISCHARGES

A complex situation drawing national attention is premature discharges. Two issues related to this subject must be clarified. The first is the perception among the beneficiary community of what constitutes a premature discharge; the second is actual premature discharge which risks patient health.

Patients' perceptions are based on several factors. Experience has taught beneficiaries that hospital stays, particularly related to recovery from operative procedures, are of sufficient length to allow the patient to leave the hospital with a high level of comfort, both physical and psychological. However, Medicare recognizes that achieving this level of comfort in an acute facility is not necessary to assure the safe recovery of the patient. Safe recovery can occur at a skilled nursing facility or often at home with proper support services.

Patients' lack of knowledge of the system, why lengths of stay are now shorter and what that means for post-hospital care leads many patients to conclude their care was inappropriate. Medicare patients are often shocked to learn their recovery will take place at home or at another health facility instead of the acute hospital. During the last year, CMRI received approximately 25 inquiries from patients who believed they still needed acute-hospital care when they were discharged. In review of these cases, CMRI determined that only one patient was actually discharged when acute-hospital care was still medically necessary. Patients need to understand that outpatient or alternative care is indeed appropriate when acute care is not medically necessary. Responsibility to provide consistent and accurate information to beneficiaries rests with the federal government, PROs, hospitals and physicians.

Not all premature discharges are misperceptions, however. CMRI and other PROs have found instances of premature discharge, some so severe as to result in a patient's death. However, at this date, we do not have sufficient evidence to determine whether we are dealing with anecdotal cases or a pattern of care.

To address these premature discharge issues, CMRI is involved in two endeavors. First, we have embarked on educational campaigns to inform beneficiaries of their rights and physicians of their responsibilities under Medicare. We believe that patients and physicians educated about the PPS system are more likely to see that appropriate hospital care and needed post-hospital support are received. To educate beneficiaries, CMRI released patient guidelines to local media outlets and federal and state legislators outlining questions beneficiaries should ask before and during hospitalization and stressing the importance of discharge planning. The purpose of these guidelines is to enhance quality of care, avoid premature discharges, plan for care after hospitalization and, in general, encourage patients to become partners in responsibility for their health care. We have also stressed the importance of discharge planning to physicians by submitting similar guidelines for statewide publication in physician bulletins.

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To determine the extent to which premature discharges occur and compromise quality of care, CMRI is one of eight PROs to contract with HCFA to conduct a special study on premature discharge during the coming year. The dual focus of CMRI's study is to: 1) review care provided to patients who reenter an acute hospital within 20 days of discharge (rather than the current 7-day readmission limitation), and 2) link available data on patients who die within 20 days of hospital discharge. CMRI, along with the other select PROs, hopes to determine the breadth of the problem, and to use our findings to educate physicians and Medicare patients to prevent inappropriate discharge.

To date, PROs have focused quality review efforts on acute-hospital care. However, there is no mechanism to assure that patients will receive quality care once they leave the hospital. Thus, skilled nursing facility, nursing home and home health care patients are not currently assured of receiving quality care. It makes sense for PRO quality assurance activities to be expanded to address these quality concerns before patterns inconsistent with the best outcome for beneficiaries are established.

CARE OF THE TERMINALLY ILL

A final issue related to acute inpatient care is the support of the terminally ill patient in their final days of life. This patient may be admitted to an acute-care facility when a family can no longer care for the patient at home and knows little or nothing of alternative care resources.

More disconcerting is an increase in admission of terminally ill patients from nursing homes or custodial care facilities unable or unwilling to continue care of the patient without taking extraordinatry measures. Instead, the patient is transported to an acute hospital emergency room leaving the facility no alternative but to admit the patient. The paradox occurs when a PRO must retrospectively deny payment for this admission because the need for the intensity of services delivered in the acute care setting cannot be documented.

The question posed to society is where will the terminally ill be cared for and at what cost? The federal government must make adjustments to accomodate this segment of the nation's ill. Perhaps the solution lies in a waiver of the requirement of a three-day acute hospital stay prior to admission to a Medicare reimbursed skilled nursing facility, the development of a new DRG to reimburse for necessary care, or expansion of services and funds for hospice care.

GAPS IN POST-ACUTE HOSPITAL CARE

Many recently identified quality problems are not caused by reduced length of hospital stay, but rather inappropriate clinical management of the post-acute patient. It has been well established that the resources and support system for the post-acute care patient are often inadequate or non-existent. HCFA's failure to coordinate policies between the acute care and post-acute care settings, resulting in restricted access to post-acute care services relative to need, must certainly be considered a major gap in quality under the Medicare program.

NEEDED ACTION FROM FEDERAL GOVERNMENT

The federal government must increase its efforts to see that cost-containment incentives do not compromise quality care. We urge your office, Senator Wilson, health-related legislative committees, and the Department of Health and Human Services, to support and monitor the quality of health care provided to senior citizens and expeditiously modify programs and policies when needed. We continue to urge the federal government to play a much greater role in educating beneficiaries to their health care rights under Medicare. Specifically, CMRI urges the federal government to establish a national toll-free Medicare information "hotline" to give beneficiaries immediate access to needed Medicare information and provide regular updated information on Medicare services and care using inserts with Social Security checks or routinely including updates in beneficiary mailings from the Social Security Administration.

In addition, hospitals must be provided standardized information to be given to Medicare patients upon admission, detailing their health care rights under Medicare. It is our understanding that HCFA is developing this type of information. We urge HCFA to include PROs input in writing such documents to assure that beneficiaries' concerns expressed to PROs daily are addressed. We also urge HCFA to expand PRO quality assurance activities to post-hospital settings.

Finally, PROs need a greater commitment on the part of the Department of Health and Human Services for adequate funding of state PROs to enable them to use their mandated quality assurance authority in sanctioning hospitals and physicians providing inferior or substandard care.

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CONCLUSION

Thank you again Senator Wilson for your leadership in assuring quality care under the Medicare program. Our nation's health care system remains in a period of great transition. Quality issues must be resolved as they arise if we are to maintain a high standard of health care for all. CMRI remains committed to working with the federal government to resolve threats to health-care quality and fulfilling our current mandate under the PRO program to assure that cost-containment incentives under Medicare's Prospective Payment System do not compromise quality of care for California's senior citizens.

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WILLIAM H. MONCRIEF, JR., M.D.

EDUCATION:

M.D.	Vanderbilt University Emory University School of Medicine	1944
	C&CCS College (equivalent)	1947
	National War College	1966
INTERNSHIP:	Barnes Hospital, St. Louis, Missouri	
RESIDENCY:	General and Thoracic Surgery Fitzsimons General Hospital	1950-1953
	Thoracic/Cardiovascular Surgery Walter Reed General Hospital	1956

CURRENT ACTIVITIES:

President, California Medical Review, Inc.

San Francisco Medical Society Delegate to California Medical Association House of Delegates, 1980-1984.

Active Staff of French, St. Luke's and Presbyterian Hospitals, San Francisco

Clinical teaching appointment (surgery) Stanford University School of Medicine

Member, California Office of Emergency Services, Disaster Medical Care Committee

DIPLOMATE:	American Board of Surgery	1954
	American Board of Thoracic Surgery	1957

MILITARY APPOINTMENTS (Last 15 Years Only)

Commmanding Officer, 121 Evac Hosp USARPAC, Korea	18 AUG 62
Staff Med Off, MACV, Vietnam	20 DEC 62
Dep Cdr, Tripler Army Med Ctr, Hawaii	15 OCT 64

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MILITARY APPOINTMENTS (continued)

Chief, Public Health Div, USAECMAID
(SO-7734) Wash DC w/sta Vietnam 15 JUL 66

Hosp Cdr, Brooke Gen Hosp
Ft. Sam Houston, Texas 1 AUG 68

Hosp Cdr, Letterman Gen Hosp
Presidio of SF 27 AUG 70

Cdr, Walter Reed Army Med Ctr,
Washington, DC 2 MAY 72

Retired at rank of Major General
to enter private practice of
surgery 10 JUN 73

AWARDS AND DECORATIONS:

Distinguished Service Medal
Legion of Merit with 2 Oak Leaf Clusters
Army Commendation Medal
World War II Victory Medal
Army of Occupation (Japan)
National Defense Service Medal with
Oak Leaf Cluster
Vietnam Campaign Medal with 60 Device
First Class Medal of Merit
Parachutist Badge

MEMBERSHIP:

Member, American Medical Association
Member, American Medical Peer Review
Organization
Member, California Medical Association
Member, San Francisco Medical Society
Fellow, American Thoracis Society
Member, San Francisco Surgical Society
Charter Member, Samson Thoracic Society

PUBLICATIONS:

"Perforated Peptic Ulcer in the Newborn"
Annals of Surgery, 139: 99-102, (Jan) 1954

"Thoracic Trauma"
With Forsec, J.H., et al
The Physical Therapy Review, 32: 1-6, (Oct) 1952

"An Improved Tracheal Prosthesis"
Surgical Forum, 1959 pp 350-52

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PUBLICATIONS (continued)

"An Acrylate-Amide Foam Arterial Prosthesis"
With R.W. Hardy, et al
Journal of Thoracic and Cardiovascular Surgery, 38: 652-661, (Nov) 1959

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With S.M. Levenson, et al
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"The Nuclear Weapon Explosion and Its Effect on Treatment of Soft Tissue Wounds"
Surgical Clinics of North America, Dec 1960, pp 1453-1460

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With R.W. Hardy, et al
Annals of Surgery, 151: 359-366, (Mar) 1960

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Medicare
Aetna Insurance Co.
Senators Cranston and Wilson
Congressman Bosco

December 23, 1965

Dear Sirs,

This complaint concerns the callous treatment that Medicare applies to helpless elderly patients in dire need for medical assistance. Also included is a suggestion whereby the insurance companies can drastically reduce medical expenses without robbing the sick.

This is what happened to us. Our doctors prescribed parathyroid surgery on my wife. The operation was set for 7:40 a.m. November 21st. We were told that we had to be at the hospital at 5:00 a.m. because Medicare would not permit an earlier admission. We had to be up at 3:00 a.m. to be at the hospital on time. I vigorously protested because my wife needed all the rest she could get prior to the 5 1/2 hour operation. I asked for admission at midnight but was refused. I then wanted to pay for the preceeding day, but was told it was against the law for the hospital to accept payment from me.

I am angry at Medicare for regulations that erode proper medical care, and I have been making inquiries about the arbitrary rules. The officers of the hospital involved said the hospital was not set up to permit admissions at midnight even though it is staffed 24 hours a day. I was also informed that the rule against early admissions was incorrectly interpreted and this hospital now accepts admissions the preceeding day.

There are three hospitals in I inquired about the admission regulations of the other two hospitals. One reply was that, if the doctor wanted an early admission, it would be granted provided that the patient entered the hospital after 7:00 p.m. the preceeding day. There would not be a charge for the early admission.

The other hospital admissions office told me that a patient could be admitted the preceeding day if the doctor ordered it. Each case is supposedly determined on its merits, but Medicare has ruled only a very few times in favor of the patient. It is solely the responsibility of the doctor to secure the approval of Medicare in advance.

I found the hospital staffs are unanimous in condemnation of Medicare rules. There are other ways to reduce the costs of medical care.

It takes 2 or 3 months for hospitals, doctors and suppliers of medical services to collect from Medicare, and even longer to get paid by insurance companies who do not pay the bills until Medicare does so. It has been estimated that the hospitals in need a working capital of over a million dollars to finance the delayed payments for one month. I have no estimate for the amount of working capital needed for other medical suppliers. Consider the tremendous financial burden imposed on medical facilities by the failure to pay the bills promptly.

We would appreciate investigation and correction of Medicare regulations that impair proper medical care of the elderly.

Thank you.

Yours truly

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CALIFORNIA MEDICAL REVIEW INC.

[illegible] • SUITE 1100 • SAN FRANCISCO • CALIFORNIA 94109 • (415) 923-7000

WILLIAM G. MORSE III, M.D., President JUDITH H. ROSS, Executive Director

date

title fname name
State Capitol
Room room
Sacramento, CA 95814

Attn: attn

Dear title name:

As you may know, California Medical Review, Inc. (CMRI) is the federally-mandated Medicare Peer Review Organization for California. We are responsible for reviewing the appropriateness, necessity and quality of health care services delivered to California's 2.3 million Medicare beneficiaries. Our prime mission is to ensure high quality care for your senior citizen constituents while helping control rising Medicare costs.

As cost containment programs strive to curb the nation's rising health care bill, quality of care issues are surfacing. Premature discharges and unnecessary and dangerous transfers of patients can and do occur. Although CMRI is reviewing care provided to Medicare patients and taking corrective action when such abuses are found, we believe that senior citizens need to be informed of how health care cost containment efforts may affect their health care.

The shift in health care from hospitalization to outpatient care has left senior citizens with information gaps. Our primary concern is that seniors need to know that Medicare's efforts to curb unnecessary hospitalizations should not result in a hospital failing to provide medically necessary care. While hospitals are indeed under pressure to contain their expenditures, in no instance should they discharge a patient before the patient is well enough to leave the hospital.

In addition, Medicare beneficiaries and their families should understand the importance of planning for needed care after the patient leaves the hospital. Lack of information about outpatient care can be disruptive to the patient and his family, and hinder the patient's recovery.

The majority of hospitals and other health care facilities are adjusting to Medicare's prospective payment system by cutting the

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cost and not the quality of health care services provided to patients. Nevertheless, it is of critical importance that the public, and particularly senior citizens, be made aware of the potential abuses of some health care providers and the course of action CMRI and other health care organizations are taking to mitigate this problem and ensure that quality of care remains the ultimate priority in health care delivery. If this issue is not addressed, private sector cost containment efforts could produce similar repercussions and threaten quality of care for private patient health care delivery.

CMRI's staff of physicians and health care professionals are available to meet with senior groups and your staff to discuss these issues, and answer questions seniors have about Medicare and the PRO program in general or address specific quality of care problems faced by Medicare beneficiaries. In addition, we would like to keep you informed of developments in the Medicare peer review program that will impact your senior citizen constituents and provide you with materials to help senior citizens keep abreast of changes in health care affecting them.

Enclosed for your consideration is a short article touching on some of these concerns which can be used by your office in a newsletter or news release.

If you, your staff, or senior citizen constituents have questions regarding Medicare peer review or other related health care issues, please feel free to call my office at (415) 923-2000.

Thank you for your time and consideration.

Sincerely,

Jo Ellen H. Ross
Executive Director

Enclosures (2)

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GUIDELINES HELP SENIORS RECEIVE QUALITY HEALTH CARE

(DRAFT COPY FOR PRESS RELEASE, CONSTITUENT MAILING OR NEWSLETTER)

(Dateline) -- Concerned that Medicare patients may be sent home from hospitals before they are well enough, (Senator/Assemblyman) _____ _____ recently released guidelines to help inform senior citizens of their health care rights under the federal Medicare program.

"With increasing financial pressure on hospitals to reduce costs, hospitals are discharging patients sooner and patients are recovering post-operatively in their homes or at alternative health care facilities such as nursing or convalescent homes," notes _____.

"This trend requires patients and their families to understand and become more involved in health care received during hospitalization and on an outpatient basis."

To help Medicare patients understand their right to quality health care and how to become involved in planning for hospitalization and aftercare, _____ urges his/her constituents to keep these guidelines in mind:

- Medicare's fixed-price payment system does not dictate the number of days a patient can be hospitalized.
- Patients should not be discharged or transferred from a hospital until it is medically appropriate, regardless of how long the patient has been hospitalized.
- Only the attending physician can authorize hospital discharge or transfer to another facility.
- Once hospitalized, patients should consult regularly with their physician to assess their progress and discharge preparation.

(Senator/Assemblyman) _____ also urges constituents with questions on hospital care of Medicare patients to contact California Medical Review, Inc. (CMRI), the state's Medicare Peer Review Organization (PRO).

"Under a contract with the federal government, CMRI reviews the quality and necessity of health care provided to the state's 2.3 million Medicare beneficiaries and ensures that health-care cost-cutting does not compromise quality of care," notes _____.

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He/She recommends that Medicare beneficiaries contact CMRI if they believe they have not received adequate hospital care or that the Medicare system has been abused. "CMRI takes corrective action against hospitals and physicians who do not provide quality care by educating physicians or, in some instances, removing a hospital or physician from the Medicare program."

In addition, two senior citizens represent Medicare beneficiaries on CMRI's Board of Directors and are available to answer questions from Medicare patients. Herbert Williams, member of the American Association of Retired Persons, and Eva Skinner, member of the Gray Panthers, can be contacted by writing to or telephoning California Medical Review, Inc., 1388 Sutter Street, San Francisco, CA 94109, attention: Administration (415)923-2000.

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CALIFORNIA MEDICAL REVIEW INC.

[illegible] STREET • SUITE 1100 • SAN FRANCISCO • CALIFORNIA 94109 • (415) 923-2000

[illegible] M.D. President [illegible] Executive Director

CONTACT
Sharon Ahern
(415) 923-2029

FOR IMMEDIATE RELEASE
September 17, 1985

STATE PRO GUIDELINES HELP PATIENTS RECEIVE QUALITY OF CARE

(San Francisco) -- California Medical Review, Inc. (CMRI), the state's Medicare Peer Review Organization, today released guidelines to help ensure that patients are not sent home from the hospital too soon and receive needed care after hospitalization.

"With increasing financial pressure on hospitals to reduce expenditures, patients are being discharged from hospitals sooner and are recovering post-operatively in their homes or at health care facilities such as nursing or convalescent homes," says CMRI President William H. Moncrief, Jr., M.D.

"Although CMRI believes this is a positive step toward efficient and quality health care delivery, it requires patients and their families to become more involved in health care planning by asking their physician how much and what type of care they will receive after they leave the hospital," notes Moncrief.

CMRI recommends that patients or their families discuss these questions with the attending physician before hospitalization:

- Where will the patient recover -- at home or at another health care facility?
- What type of care will be needed after the patient leaves the hospital? (e.g., visiting nurse, home health care assistance, bandage changes, special diet)
- Who will teach the patient and his family how to enhance recovery?
- How much discomfort can the patient expect during recovery?

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- o What facilities provide outpatient care?
- o Is transportation available from the hospital to the patient's home or outpatient care facility?

To ensure that patients, especially Medicare beneficiaries, are not sent home from the hospital before they are well enough, CMRI urges the public to keep these guidelines in mind:

- o Medicare's fixed-price payment system does not dictate the number of days a patient can be hospitalized.
- o Once hospitalized, patients should consult regularly with their physician to assess their progress and discharge plan.
- o Patients should not be discharged or transferred from a hospital until it is medically appropriate, regardless of how long they have been hospitalized.
- o Only the attending physician can authorize hospital discharge or transfer to another facility.

"Patients who take time to understand their own health care will know what to expect when they enter and leave the hospital," says Moncrief.

"Such preparation will also help patients dispel fears, ensure quality care is received, and, more importantly, make recovery as quick and comfortable as possible," he adds.

For more information on hospital care, the Medicare peer review program or CMRI, call or write Sharon Ahern, California Medical Review, Inc., 1388 Sutter Street, Suite 1[illegible], San Francisco, CA 94109, (415) 923-2000.

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CALIFORNIA MEDICAL REVIEW INC
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[illegible]

FOR IMMEDIATE RELEASE

Contact: Sharon Ahern
(415) 923-2029

CMRI URGES PHYSICIANS TO MORE ACTIVELY PARTICIPATE IN DISCHARGE PLANNING

To help assure that Medicare patients are discharged from hospitals to the appropriate environment for safe, optimum recovery, California Medical Review, Inc. (CMRI), the state's Medicare Peer Review Organization, is urging physicians to more actively participate in the discharge planning process. Since patients are being discharged sooner and requiring more sophisticated post-discharge care, CMRI recommends that physicians work even more closely with hospital discharge planners, patients and patients' families when post-hospital care is being arranged.

In response to inquiries from individual patients and senior citizen groups suggesting that Medicare beneficiaries are seriously concerned about post-hospital care, CMRI suggests that physicians discuss these questions with Medicare patients and their families before elective hospitalization or as soon as possible after a non-elective admission:

- Where will the patient recover -- at home or at another health care facility?
- What type and intensity of care will be needed after the patient leaves the hospital?
- Who will teach the patient and his family how to enhance recovery?
- Is transportation available from the hospital to the patient's home or outpatient care facility?

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Los Angeles Times Sunday, December 29, 1985/Part IV

Watchdog for Quality and Costs

New Power Rises Over Health Field

By JONATHAN PETERSON,
Times Staff Writer

Within the last year, a little-known organization called California Medical Review Inc. has quietly applied broad federal powers to influence how hospitals handle their Medicare beneficiaries, including—in some cases—whether older patients are allowed to check in overnight or even be operated on.

While little recognized outside the health-care field, CMRI—as it is referred to within the medical community—has a far-reaching mandate: To watch over the quality of Medicare, the federal health insurance program for people over 65, while also determining whether services given a patient are necessary and reasonable.

In essence, it has become both judge and enforcer of key aspects of medical practice under the giant federal program that provides some 40% of hospital revenue in the state.

In just over a year, the watchdog group has blocked more than $35 million in federal reimbursement to hospitals for admissions it judged either unnecessary or too long and gained authority to seek monetary sanctions against hospitals and doctors for substandard care.

Please see CMRI, Page 5

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2 Part IV/Sunday, December 29, 1985

CMRI: Little Recognized Firm Is a New Power Rising Over Health Field

Continued from Page 1

In addition, it has pressured hospitals to send their elderly patients home after treatment for certain conditions rather than admitting them to hospitals overnight.

And to the unease of established medical interests, the nonprofit corporation seeks an even broader role to review the "appropriateness" of medical care, one that potentially would affect patients of all ages.

That it has begun offering consulting services to private employers and hopes that its limited role as a reviewer of Medical, a government health-care program for the poor, may be extended.

As a result, members of the medical community are keeping a wary but eye on the organization.

"They are potentially a very powerful group, and that's why I think we have to watch them closely and make sure they don't misuse that power," said Tom Reardon, a Berkeley physician who is chairman of a California Medical Assn. panel that keeps tabs on CMRI.

CMRI officials, meanwhile, say the organization already has had a positive impact. "If the patient doesn't really need to be in the hospital, there's not much reason for him to be," said the board's president, William H. Moncrief Jr., a thoracic surgeon and retired major general who was decorated for service with the Army in Vietnam. "... I think we've had a tremendous impact on practice patterns."

Calls on Consultants

CMRI just emerged as a major player in the state's multi-billion-dollar hospital industry in October, 1984, after winning a $27-million federal contract to become California's "peer review organization" for Medicare.

Before that, such authority was spread out among 28 organizations, under a system sometimes criticized for being too lenient in cases of questionable care.

When federal officials decided to scrap the old review system, a majority of the 28 review groups joined together to form CMRI in San Francisco.

Since bidding successfully for the two-year federal contract, CMRI has set up 16 offices throughout the state and set loose 170 trained reviewers, mostly nurses, to check on hospital records.

In addition, CMRI calls on the services of paid physician-consultants when hospitals challenge its findings. Officials estimate that CMRI ultimately will review some 40% of the state's 900,000 to 950,000 admissions for Medicare this year.

The organization counts 22,000 doctors whom it inherited from the previous review groups as its membership, a figure that is roughly one-third of the state's physicians. But power is concentrated in a board of 18 doctors, two hospital administrators and two Medicare beneficiaries. (Moncrief receives $50 an hour and expenses for his 15-to-18-hour-a-week duties as president.)

Many Doctors Agree

In its relatively brief existence, CMRI already has had a significant impact on the way hospitals do business.

- With the implied threat of blocking federal payments, CMRI has accelerated a trend in hospitals of treating Medicare patients without admitting them overnight for a handful of prescribed conditions.

CMRI officials say that the $35 million being withheld from hospitals includes unnecessary admissions related to congestive heart failure, pneumonia, diabetes, back problems and a variety of other ailments.

Many doctors agree that the practice of steering patients toward their own beds rather than those of the hospital often can be done safely, while yielding cost savings.

Also, CMRI allows exceptions if doctors get advance permission. Nonetheless, some have questioned whether blocking reimbursement for admissions based on a subsequent review of records is fair in light of the individual nature of each hospital case.

- For one type of problem, cataracts, CMRI pressure appears to have nearly eliminated the practice of admitting elderly patients to the hospital.

Before the federal watchdog gained its authority, California hospitals admitted some 2,000 cataract patients each month. By April, 1985, that number had plummeted to 180 admissions, the remaining patients treated on a "come and go" basis, according to CMRI.

- Under authority granted earlier this year by the federal government, CMRI is recommending that officials financially penalize hospitals and doctors for several cases of care deemed substandard.

Action has begun on another 37 sanctions and officials predict the number may reach 100 next year. Nonetheless, said CMRI's Assistant Medical Director John T. Kelly, "It's only a small number of physicians in a small number of hospitals

ROBERT KAUFMAN

William H. Moncrief Jr., president of CMRI

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that we have identified as having significant quality problems."

• CMRI is exercising some authority over medical decisions that previously belonged to doctors.

For example, in an attempt to prevent unnecessary surgery, the organization now requires doctors to call an 800 telephone number to get CMRI's permission to perform certain elective procedures, such as coronary artery bypass operations, gallbladder removals and hip replacements. Advance permission is not required for emergencies. MediCal and some private insurance programs have previously required similar advance approval, but the procedure is a new one for Medicare, according to CMRI.

Majority Approved

In practice, the vast majority of requests are approved, possibly because physicians are learning not to request unnecessary procedures, CMRI officials said.

Moncrief acknowledged in an interview that not all doctors are enthusiastic about working with CMRI and telling their peers they're doing something wrong. "Nobody wants to say no."

But he contended that CMRI's power of the purse was prompting greater efficiency in the health-care system. "I would think that next year we might see a smaller number of dollars denied because the hospitals are getting smarter, and they're forcing the doctors to practice appropriate medicine."

Many hospital officials apparently believe that CMRI is doing a good job in carrying out its mandate, although various questions and concerns remain.

A recent survey by the California Hospital Assn. found that 78% of hospitals considered their experience with CMRI to be satisfactory or very positive, although communication and costs of photocopying and postage—sometimes $50 for a single hospital case—caused concern.

C. Duane Dauner, president of the hospital association, said that CMRI had gone through "normal growing pains" in setting up its bureaucracy and credited it with a good job in responding to its federal mandate.

But he complained that hospitals were unfairly penalized when federal reimbursement was denied, and questioned whether its reviewers relied too heavily on impersonal formulas when evaluating the appropriateness of a hospitalization.

'Medicare Won't Pay'

"Doctors can still admit the patient, but the difficulty for us as hospitals is that Medicare won't pay the hospital anything," Dauner said. "Therefore we end up between a rock and a hard spot because we provide the care that was ordered by the physician and we receive no payment."

However, according to CMRI, if a bill is disallowed, the patient is held responsible for little or none of the costs.

Dauner said that CMRI's system of relying on formal criteria for evaluating whether a patient should have been hospitalized, after the fact, comes close to "cookbook medicine," adding: "When you're dealing down at the bedside it's not as easy as looking at 11,000 cases in a book."

One of the fundamental questions about CMRI is whether its mission is more to promote quality of care or savings in cost. According to its own press release, CMRI's role is to review the "quality and cost" of health care for Medicare beneficiaries.

Jeffrey S. Kirschner, a vice president of American Medical International, which owns 21 hospitals in California, said he had not observed a concerted effort by CMRI "to address the issues of the quality of health care in our facilities."

Despite skepticism in the hospital community, CMRI officials are publicly stressing their role as guardians of quality, particularly in light of concerns raised about the effect a new, tighter Medicare reimbursement system is having on hospital care of the elderly.

"If we can ensure quality of care to the Medicare beneficiary, that's our goal," Moncrief said. "And if a spin-off is saving money, well great."

CMRI officials would like to extend their vision of appropriate medicine to other areas, including post-hospital stays in nursing homes and MediCal.

(CMRI already has a $1.5-million state contract to review care under MediCal in six Central California counties and 38 communities in Los Angeles.)

CMRI also has begun offering its services to private employers interested in monitoring their employees' health care costs and the level of care they receive.

And in what would be a significant expansion of authority, federal officials are debating whether CMRI and similar organizations elsewhere should withhold doctors' payments for unnecessary treatment under Medicare.

Currently, CMRI's power to deny such reimbursement is limited to charges by hospitals.

"I think it's about time we put some heat on the doctors," Moncrief said. "Up to this point the hospitals have been taking the financial heat."

Fears Over Expanding Role

The possibility of such a growing role leads some to wonder whether CMRI could evolve into an excessively powerful arm of the federal government, dictating medical practice throughout the health-care system.

"Our concern is that in any system there have to be differences of opinion," said Stephen E. Dixon, a vice president with National Medical Enterprises, which owns or manages 33 hospitals in California. "A single, monolithic system would provide us with what everybody would worry about—pure, cookbook medicine."

Moncrief responds that as long as doctors hold the watchdog's leash, CMRI will not seek an undue concentration of power.

"As long as practicing physicians, who should be responsive to the physician communities in which they practice, are controlling the organization, then I don't see any problem," he said.

Senator WILSON. Thank you very much, Dr. Moncrief.

Ms. Skinner, in your testimony you have emphasized the need for the kind of post-acute care services that presumably in several of the cases that you have cited, might have made the difference between literally life and death.

The recommendation that you have made has been echoed in other testimony.

You are in an interesting position, you and Dr. Moncrief, as members of a PRO, I think, give a particular perspective, and the question that I really have first for you, and later to him, is this. If we are going to have the PRO's engage in additional monitoring of the skilled nursing facilities and other post-acute care facilities, one additional burden that places on the PRO's, are they going to be able to handle it or does it, as I gather from Dr. Moncrief's testimony, involve the requirement for significant new resources?

Ms. SKINNER. Certainly I think that the PRO's are capable of handling an extension of their scope of work into the skilled nursing facility.

I also feel that that is a very, very important next step. I have to agree though, that it will require more money in order for the PRO to extend their work. Any increase in a workload like that is going to mean increase in staff, but as far as capacity and capability are concerned, there is absolutely no question in my mind that what they are able.

I would also like to state that despite the fact that there have been commendable efforts on the part of the quality review organization in the State of California related to skilled nursing facilities, they still are not doing what I feel is enough to bring skilled nursing facility care up to what it should be. We are a bit lax, I feel, perhaps even more than a little lax in terms of a rigid and well-adhered to criteria for preadmission screening to the skilled nursing facility and quality care after admission. I think the PRO could function very well in this role.

Senator WILSON. Is there adequate diagnostic capability in the skilled nursing facility?

Ms. SKINNER. In the facility itself?

Senator WILSON. Yes; in other words, although a couple of the examples that you related really had to do with some questionable diagnosis in the acute care facility.

Ms. SKINNER. Yes; the cases which I cited and which had been identified as a misdiagnosis or inappropriate diagnosis, are the responsibility of the medical staff, and occur before the patient reaches the skilled nursing facility.

Senator WILSON. I understood that. My question really is about the capability in the SNF's for a diagnosis that might catch a complication, that might avoid what—it sounds from your testimony as though is a frequent occurrence, which is that patients are sent from acute care facilities to these post-acute care situations in which they worsen and die.

Ms. SKINNER. I think that certainly in terms of nursing diagnosis, nursing plan, this is rather carefully adhered to as much as possible considering the shortage of staff and not too well-trained staff in the skilled nursing facilities. However, we must recognize that according to the present California State law, a physician is

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only required under MediCal, to visit his patient in a skilled nursing facility once every 30 days. So that even if he or she, the physician, may be an expert in diagnosis, a lot could happen in the intervening 30 days.

I hope that answers your question.

Senator Wilson, I think we must realize the importance entire continuum of care, community based as well as the skilled nursing facility in the whole scope of treatment.

According to the hearing of your committee which was held in Washington, I think on October 24, the statement is made under problems, since implementation of the PPS system, there has been a 40-percent increase in discharges to skilled nursing facilities, and a 37-percent increase in discharges to home health agency care.

I think that is a little in contradiction, Mr. Fleming, to what you said. I feel it is important that I reread this material.

Senator WILSON. Another question I wanted to ask you is whether you agree with Mr. Fleming's statement that the present system of surveying certification gives sufficient assurance of the adequacy of care in the post-acute care facilities?

Ms. SKINNER. No; I am sorry, I don't agree. I have had probably more than 25 years' experience of working both in a medical center and in community-based facilities, including skilled nursing facilities, dealing purely with geriatric patients. I feel that the present method of serving and evaluating the care is sadly lacking. I feel that the PRO's need to be involved in skilled nursing facility care, and that the need is desperate and I hope that your committee considers this very seriously.

Senator WILSON. Thank you.

Mr. Gould, do you agree with Mr. Fleming that the informed patient is best assurance, really, that we will see quality care given to recipients?

Mr. GOULD. Certainly the patients today are not adequately informed, and in many cases where they are, they are confused, a lack of understanding.

The concept in educating the beneficiaries at the carrier where I was employed, no longer does that due to cost containment. I presume, from what has been said, that the Health Care Financing Administration is going to focus on education. I was very directly involved, seeking out and educating the beneficiaries in the needs, the rights and what to expect, what they can look for, what to avoid, how to do it, and it no longer is being done, and it is badly needed, I know from my personal contacts and voluntary assistance.

I agree with Mr. Fleming that it should be done, but I don't know how it is going to be done in the PPS program.

Let me give you an illustration of what I am saying, I just happen to have it with me.

This is just one volume of the PRO costing of providers and Medicare assignment. This is one of several volumes, this contains only the metro Los Angeles part of six counties in southern California—2 geographic areas.

This became available in December 1984. It is now badly out of date, it has the percentage of assignments that are accepted by the physicians, and as late as yesterday, I checked with the carrier and

found that the assignment rate, I am very happy to learn, has risen to 80 percent on claims presented currently, as compared to less than 60 percent in the volume which I have.

However, these were published annually on a continuing resolution, which has not been continued as of this date. Accordingly, there is no definite plan with a carrier of reissuing this, and the earliest it could now be reissued, is about next June if the law were passed now. Thus all the education used to educate the beneficiaries on how to find physicians who will accept assignment is lost, because the information is no longer available as of this date.

So, we need help, we need help in getting the word out by all means. I am ready to help in that effort in any way that I can.

Senator WILSON. Thank you.

I gather that there is some unanimity on the part of the panel in the need for improving the information available to the recipients, and I note that Mr. Fleming has been at some pains to detail the efforts that have been made by HCFA to try to inform patients, yet for all of the efforts that have been made, Mr. Fleming, there seems to be clearly gaps in the awareness of a number of patients, and while I sympathize with the difficulty of the task, it is always difficult to inform consumer citizens of their rights.

There seems also to be a consensus at least among the other members of the panel, that for this to be effective it should occur in a preadmission setting. I know that many of your efforts are directed to achieve that.

One of the defects though, it seems, is that the PRO manual which HCFA has put out, states that the hospitals are permitted, "they are permitted" to issue denial notices to the patients, but hospitals are not now required to issue any notice to patients unless they expect to bill that patient. Apparently some hospitals are not issuing such a notice.

Would you support making the notices mandatory in all instances prior to discharge?

Mr. FLEMING. Senator, we are in the process of doing a number of things with regard to notifying patients of their rights under the Medicare benefit.

One of the most important is we have in draft stage right now, a written notification of patients rights which will cover what they should do in the event of a denial notice; hospitals will be notifying patients of denial in order to protect those rights. This notice is in draft stage and we are working with several senior citizen groups to perfect the language of that so it is clear and easily understood. Once this notice has been finalized, we will ensure that every patient upon admission receives a copy of those rights, and where necessary, family and those who are concerned about the patient will also be informed.

We are, as are Medicare beneficiaries and yourself, very concerned about the patients understanding.

Senator WILSON. Does that mean that the administration is considering making it mandatory?

Mr. FLEMING. I can't answer that directly; I can't tell you that we are considering making it mandatory. I know in the written notification will be provided patients to ensure that they are are aware of what their rights are under denial.

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Senator WILSON. Dr. Moncrief, do you think it should be mandatory?

Dr. MONCRIEF. I don't know, sir, I think it would help but I think it has to be looked at very carefully. At the present time if the hospital issues a denial letter to a patient, or proposes to issue a denial letter to a patient for a continued hospital stay, under Medicare reimbursement, and the attending physician does not agree with that decision, the PRO must review that particular hospitalization, and within 24 hours make a decision and inform the hospital whether they agree with the hospital, or whether they agree with the attending physician.

Should the attending physician agree that continued acute hospital stay is no longer required, then the hospital of course can go ahead and issue the letter. Whether it should be routine on all patients, I don't know.

I would like to address a point to a question that you asked Eva Skinner, can the PRO's handle post-acute care review.

The original contract that the PRO's have is very proscriptive, and I can understand the reason for that. There was need for rapid implementation of the program and everything else. The new scope of work, I think, is going to give the PRO's more flexibility; more flexibility to focus on specific areas instead of doing an across-the-board review. And should the new scope of work for the new contract period be as flexible as I think it might be, I think a lot of the PRO's will have the resources to do post acute hospital care review. Certainly in a focused area.

Mr. FLEMING. If I might also respond to a statement that Ms. Skinner made with regard to the increase of discharges to home health and skilled nursing facilities. Ms. Skinner's statement that these discharges have increased by 40 percent is true, but it remains a very small percentage of overall discharges.

Discharges to skilled nursing facilities in 1984 were 5.3 percent of all PPS hospitals, and in 1985 rose to 5.8 percent. In 1984, discharges to home health services were 3.1 percent and 1985 rose to 3.8 percent. So, while they are up 40 percent, 40 percent is a very small percentage of a rather small base of those discharges to post-acute care facilities.

Senator WILSON. It still revolves around the size and number of patients though.

Mr. GOULD. I was a recipient to some home health services after my 20-day hospital stay. The services had to do with daily changing of a bandage on a T-tube inserted inside me, and flushing it twice a day. I was shown how to do it by a nurse before I went home, I went home over a weekend and in no way could I do it. I had one heck of a time getting some help so I could have it done. My wife almost fainted every time she saw anything going on in that area.

My surgeon, a very outstanding surgeon, knew very little of the details about the system of home health services. The nurses usually handle the home health care services and do so beautifully. I think they should be given more consideration in the home health care program, the patients certainly need more education in this area of services.

Senator WILSON. Dr. Moncrief, did you wish to comment?

Dr. MONCRIEF. I think this points out another need for education. In this instance as Mr. Gould just related, the physician has to be educated. The physician has the ultimate responsibility for that patient's care. He is the one that has to tell the nurse what to do. The nurse is not going to do it on her own.

I would like to support one thing that HCFA is doing. That is the new post-acute hospital care survey. It remains to be seen if this will improve what Eva Skinner and I both know exists in the real world, which is the quality of care in the skilled nursing and long term care environment. But there is no question that HCFA does plan a closer monitoring and instead of looking at policies and procedures, looking exactly how this care is delivered, actually observing patient care and patient response to the care.

They are certainly going to put the resources in it; I hope they put enough resources in it because it is a start. At the present time I can only endorse Eva Skinner's comments that across-the-board, long-term care is pretty sad in California.

Mr. FLEMING. In that review process, we will be focusing on patient outcomes for the first time. We think that is an important step.

Senator WILSON. Let me ask this question, a related question.

I was very much interested in the statement which you made, Mr. Fleming, that HCFA plans that patients will soon be visited in their homes. If you are going to require State survey agencies to begin monitoring this aspect of health care delivery, then, what quality insurance inspection guidelines have been developed for State inspections to use and identify and to correct substandard home health care?

Mr. FLEMING. May I submit that for the record, Senator, I don't have that with me, and I will submit that for the record.

[Subsequent to the hearing, the following was submitted for the record:]

State agency surveyors are provided with guidelines which interpret the home health agency statutory and regulatory requirements relating to the health and safety of patients. For example, these guidelines include instructions concerning reviewing patients' clinical records to assure that each patient has an individualized plan that is periodically updated and documented. This plan must include, among other things, patient diagnoses, types of services and equipment required, frequency of visits, prognosis, functional limitations, nutritional requirements, medications, treatments and other safety measures to protect against illness and injury. These guidelines are updated as requirements change, problems are identified or interpretations need to be clarified.

In December 1985 we added provisions to the guidelines that would allow for State agency surveyors to visit patients in their homes to observe the care and treatment provided by home health agencies (HHAs). Findings from these visits become a part of the HHA certification process and will assist State agencies in determining whether HHAs are complying with Medicare health and safety requirements. However, a patient is not visited unless he/she is notified in advance and agrees to the visit.

Senator WILSON. OK; I look forward to HCFA's prompt response.

Let me ask you specifically what is being done about what repeatedly has been described as anecdotal experiences this morning. There has been 368 potentially premature discharges in California cited in your written testimony. That is a large number, whatever it works out to be as a percentage.

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I am interested first in the kinds of sanctions that have been brought against the offenders, and I am interested in how many times doctors stood up and said to the PRO, no, you are wrong, my patient deserves to be in this hospital, and I insist that he or she stay.

Mr. FLEMING. Let me answer part of that, and perhaps Dr. Moncrief would like to respond to part of it.

The number nationwide is about 4,000 cases that we see may indicate premature discharge. We really believe one is too many, and each one that we are made aware of needs to be addressed. We require the PRO's and the regional office and perhaps fiscal intermediaries to inform us of cases that they are aware of, and they are followed up.

As far as sanctions go, there could be a denial of a readmission in which case the hospital or provider could not shift responsibility for payment to the patient. If there are repeated patterns there are sanctions, including denial of payment for readmission to possible exclusion from the Medicare Program.

As far as how many doctors have actually stood up and said no to a hospital, perhaps Dr. Moncrief can address that.

Dr. MONCRIEF. I think there is a significant number that do. The premature discharge numbers are rather soft because the numbers that are developed are developed from a so-called 516 report which is a series of reports which the PRO's are obligated to submit monthly to HCFA. But the premature discharge as identified in the 516 report, are premature discharges that result in readmission. We don't have an accounting of the premature discharges that result in death at home, or that never have to come back into the hospital. This is one of the things that CMRI, I hope to do, with this research proposal this coming year. To find out those that have died or that haven't—at the present time our readmission review is limited to those readmitted within 7 days after discharge. We are going to stretch that out to 20 days. There are some PRO's that would like to see it out to 60 days.

As far as the premature discharges, the number of 368 or whatever it is, these are premature discharges that are identified retrospectively. When we look at those a little closer, we find that the initial assumption of premature discharge was based on poor documentation, and when we ask the physician further, that he gives additional information, that by far the greater majority of those 368, over 200 were felt to be appropriate discharges.

Another point is the community standard of practice of medicine. An instance in point is a patient that is admitted for coronary artery studies, coronary angiograms, and the physician then tells the patient, "Well, Mr. Smith, you are going to have to have a four vessel bypass graft"; and the patient says, "Oh, wait a minute. I want the kids to come up from Southern California or I want to see my lawyer; I want to get my will; I have some personal things." The patient is discharged and then is readmitted 5 or 6 days later. That is a readmission and under the old rules was identified as a premature discharge. But it is a sequential admission instead of a premature discharge.

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Senator WILSON. What you are saying, Doctor, is that the explanation for a lot of these anecdotal episodes is that it was good medicine but bad record keeping?

Dr. MONCRIEF. That's right. I think there are a significant number of "premature discharges," but when you look at it when you separate the "sheep from the goats," you find that we get down to anecdotal cases. But I agree that is plenty; one is too many. As far as sanctions go, we have forwarded four sanctions to the inspector general, and none of those are based on premature discharges. We have others under investigation.

Ms. SKINNER. Senator Wilson, may I just say one thing?

The cases that I have cited during my testimony, are not just anecdotal. These are cases that have been reviewed, where consultants have been brought in, where the case has been discussed with hospital administrators and with the attending physicians. Now these cases are being considered in terms of the level of sanction that will be recommended.

Senator WILSON. Let me just pursue with Mr. Fleming and Dr. Moncrief, I am obviously heartened by the statements of the kind that you made, Mr. Fleming, that to quote your written statement: HCFA should vigorously pursue each and every potential case of quality abuse and initiate sanction when appropriate.

But frankly there seems to be a gap between that stated intention and the performance in the specific regard that was mentioned in a memorandum—you have seen it before, but let me provide it to you now again.

[The complete memorandum of November 25, 1985, from Richard P. Kusserow, inspector general, HHS, to C. McClain Haddow, Acting Administrator, HCFA, with November 26, 1985, response follows:]

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 25 1985

From Richard P. Kusserow
Inspector General

Subject Early Alert: Inappropriate Discharges and Transfers Under the Medicare Prospective Payment System (PPS) - Information Memorandum

To C. McClain Haddow
Acting Administrator
Health Care Financing Administration

The purpose of this memorandum is to alert you to the preliminary findings of our inspection concerning inappropriate discharges and transfers under PPS.

The Office of Analysis and Inspections is conducting a study of the 4,724 cases of suspected inappropriate discharges and transfers referred to the HCFA Regional Offices by the various medical review entities during the period of October 1, 1983 through May 31, 1985. The objectives of our review are to:

1. determine the number of documented cases of inappropriate discharge or transfer during this period;

2. categorize the cases and document their disposition;

3. review the appropriateness of corrective actions taken by HCFA or the PROs on any potentially gross and flagrant instance of substandard care; and

4. examine the existing procedures pertaining to the identification and disposition of these cases.

The early findings of our inspection have disclosed serious deficiencies in the procedures used by the PROs and HCFA concerning the analysis and resolution of cases of inappropriate discharges and transfers. Specifically we are deeply concerned that:

1. We are unable to find supporting documentation on a large number of the reported cases.

2. We have found numerous cases of substandard care in which there was little or no action by the PROs.

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3. We have grouped the referred cases by provider and have identified patterns of potential violations by a number of providers. In the vast majority of cases these patterns have escaped identification by PROs and consequently little or no effective corrective action has been taken.

Based on our preliminary findings we are deeply troubled at the ineffectiveness of the existing procedures used by PROs to review cases of substandard care. We believe that it is imperative that HCFA take strong action to place more emphasis on PRO responsibilities for analyzing raw data and taking corrective action where there are patterns of poor quality of care.

We will continue to develop information related to serious quality of care violations and to patterns of less serious violations committed by certain physicians and providers. In a number of cases we will forward our information back to the PROs for more development.

We will keep you informed of our findings as our work continues. We are prepared to meet with your staff to discuss our findings. Contact can be made with Barry Steeley on FTS 472-5343 to arrange a meeting.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Memorandum

Date 11/26/85

From C. McClain Haddow
Acting Administrator

Subject Inappropriate Discharges and Transfers Under the Medicare Prospective Payment System (Your Information Memorandum of November 25)

To Richard P. Kusserow
Inspector General

We are quite surprised by the conclusions in the subject information memorandum.

First, we certainly share your concern that PROs become more active with respect to assuring the quality of care provided to Medicare beneficiaries. Our commitment to this is reflected in the modifications we have proposed to the PRO Scope of Work, which include application of generic quality screens to all cases under review and increased attention to patient status at the time of hospital discharge. Further, we will gladly accept your offer of further staff discussion of your findings. I must pass along to you, however, my strong disagreement with your "preliminary conclusions", and my puzzlement over them.

- Although your memorandum states you are studying 4,724 cases, in fact you actually reviewed slightly less than 3700. Of these cases, many predated PROs and were reviewed by PSROs or fiscal intermediaries, neither of which had "clout" to deal with quality issues. These cases are not appropriate for discussions about how well PROs are doing their jobs.

- Of the cases you reviewed that were actually handled by PROs, all but a handful predated the effective date of the PRO sanction regulations (May 17, 1985) which first provided the PROs with real authority to deal with serious quality problems, and all of them predated the release of the "premature discharge" instructions (cleared by the Office of General Counsel on July 25, 1985) which first gave the PROs authority to deny payment on at least some readmissions because of inappropriate prior care. Thus, the IG study limited itself to cases handled by PROs before they had all the tools they now have to deal with quality problems. It is simply incorrect to assume that PROs are handling cases now the way they did during the period of the study.

- Most disturbing of all, our respective staffs met on October 16, 1985 for the purpose of discussing the preliminary findings referred to in your memorandum. At no time during that meeting were any of the findings characterized as "disclosing serious deficiencies", or being "deeply troubling" by IG participants. In fact, there was no indication of major problems.

In the implementation of complex new programs like PRO, it is not reasonable to expect that all possible problems will be anticipated, or that snags and delays in implementation will not occur. It is reasonable, however, to expect us to identify problems, fix them, and learn from experience to strengthen overall program administration. We believe we have done this with the PROs. We would certainly be interested in any positive suggestions you might have to improve our quality review procedures as they now stand, or to improve the quality activities for PROs laid out in the second Scope of Work.

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This is a memorandum that was an intra-department memorandum from the Inspector General, Richard Kusserow, and dated November 25, which identified a number of cases of substandard care apparently identified by Medicare's PRO's, but not followed up. The inspector general specifically stated in the earlier word to HCFA, based on a nationwide audit of HCFA's quality assurance activities. Let me just quote from the memorandum:

The early findings of our inspection have disclosed serious deficiencies in the procedures used by the PRO's and HCFA concerning the analysis and resolution of cases of inappropriate discharges and transfers. Specifically we are deeply concerned that, (1) We are unable to find supporting documentation on a large number of reported cases.

This is a point that Dr. Moncrief was making:

(2) We have found numerous cases of sub-standard care in which there is little or no action by the PRO's, (3) We have grouped the referred cases by provider and have identified patterns of potential violations by a number of providers. In a vast majority of cases these patterns have escaped identification by PRO's, and consequently little or no effective corrective action has been taken. Based on our preliminary findings, we are deeply troubled that the ineffectiveness of the existing procedures used by PRO's to review cases of sub-standard care, and we believe that it is imperative that HCFA take strong action to place more emphasis on PRO responsibilities for analyzing raw data and taking corrective action where there are patterns of poor quality of care.

I would be interested in the response both from Mr. Fleming and from Dr. Moncrief.

Mr. FLEMING. Well, Senator, we take Inspector General Kusserow's comments very seriously and are following up on the specific cases which are not referenced in his memo. We think that his services are useful, another tool in identifying specific problems and we do want to follow up on that.

We believe the new scope of work that the PRO's will be using in 1986 in the new contract, will begin to address some of those problems because they will, as Dr. Moncrief said, give the PRO's flexibility to look more deeply into specific cases.

Dr. MONCRIEF. Senator Wilson, this is a problem, and we have identified cases in California, I am frank to admit, that from my personal standpoint, I was disappointed that we were not able to pursue more vigorously, but you have to get the physicians in that community to say that it is poor care. This is what it comes down to. If we can't get the physicians in that community to say it is poor care, then we can't pursue it. There is just no way we can do it. It is a peer review process. Sitting in the San Francisco office, it might look like disasterous care rendered a patient, as documented in the clinical record. "As documented," I have to emphasize that. When we sit down and talk with the doctors that were actually involved, it turns out to be not quite the "horrendoma" (phonetic) that it appears to be. We are aggressively pursuing these.

One of the problems in peer review is the reluctance of the practicing physician to get involved because he can get involved in litigation. He just doesn't want to do it. The PRO's have seen their liability coverage cut, our liability coverage cut from 10 million to 1 million by our carrier. It made our Directors and our employees, physician employees, awfully uncomfortable. In fact we have had some very fine physicians leave as physician advisors—physician

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reviewers—because of the lack of liability coverage. There is no question. There are problems.

I talked to Mr. Kusserow about these problems and I said, it is very easy for you to sit up here and say this is wrong, but when you get down in the trenches and you ask doctors to point fingers at other doctors, it is tough.

Senator WILSON. What is his response to that?

Dr. MONCRIEF. He just goes by the numbers, and I can appreciate his position.

Senator WILSON. Have you had instances and if you have, supply for the record, instances of where physician employees of the PRO's have been sued by doctors against whom they brought a judgment of inadequate care?

Dr. MONCRIEF. No, sir; not today. It is "sword of Damocles" hanging over these physicians who are out in the trenches and they naturally don't pursue some of these cases as vigorously as we at the leadership level would like to see them pursue.

Senator WILSON. So in other words what you are saying is that the protections that Congress has created for these PRO physicians, have not been sufficient to persuade the insurance carriers not to decrease the coverage?

Dr. MONCRIEF. I think that the peer review organizations are caught in the same liability squeeze that everybody else is, from automobile insurance to whole communities in California that can't afford insurance. I think that the carriers that furnish liability coverage for the peer review organizations, are in the same squeeze as the general insurance industry.

Senator WILSON. It is going to be my suggestion to Chairman Heinz that at least one hearing of this committee be devoted to looking at that question because it seems to me it is rather fundamental to the effective functioning of the PRO's in their most basic aspect.

Let me follow up on something you said earlier, Dr. Moncrief, what instructions have you been given by HCFA with regard to sequential admission?

Dr. MONCRIEF. There have been some clarifying memoranda come out regarding the Transmittal 85-5 which is the one that dealt with the premature discharge and sequential admission. The clarifying instructions are such that we will pursue as a premature discharge those institution instigated discharges. By that I mean in those cases where it is documented in the record, the patient requests discharge, requests delay in a surgical procedure, requests delay in a treatment program, or where it is in the standard of medical practice to do a sequential treatment program. They will be reviewed, but they will be certified. But it is those institutional, hospital, or medical staff instigated premature discharges that we will pursue.

Senator WILSON. Dr. Moncrief, I've got a follow up question that I will ask you for the record, but I will not take the time to do it now.

Let me just ask, when do you think we are going to have a prospective payment system for skilled nursing care and for home health care?

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Dr. MONCRIEF. That is going to be very difficult and complicated as I see it, because of the spectrum of care. In the acute care hospital the PPS system focused on acute care and broke it down into 471, I think, DRG's now. The spectrum of clinical care in the skilled nursing facility and long-term care, is so broad and so diverse, either they are going to have to—no, I just don't see it being feasible now. Maybe Mr. Fleming has got some ideas on that.

Mr. FLEMING. We submitted a report to Congress on prospective payment for skilled nursing facilities which was not really very definitive but gave some options and discussed some of the problems. The major problem is in the development of a data base that permits you to develop DRG's. We had adequate data bases for the part A acute care because we had years of history of hospital admissions to use and Medicare bills to use to develop that data base, but developing a DRG, a related group of diagnosis and accompanying treatments to develop a specific cluster of treatments and conditions to represent a DRG is much more difficult to develop.

As we move to the overall reimbursement reform we certainly are not ignoring SNF reimoursement reform, but it is going to require a tremendous amount of work. We look ahead toward capitation and developing a capitated payment, or a voucher if you will, for a bundle of a complete range of Medicare services for patients, to include not only the part A acute care, but also to include the physician care and community service self-care for long-term patients. In fact, I believe Secretary Heckler before she left office, sent a memorandum to the Speaker of the House urging him to begin consideration of a complete package of health care for Medicare beneficiaries, or a voucher which would incorporate a number of these services under a capitated payment. We think that in terms of incentives to provide quality care, and at the same time keeping costs down, that is the ultimate direction. I believe your colleague, Senator Durenberger, has introduced some legislation or is about to introduce legislation if he hasn't already done it, calling for a voucher system in a capitated bundling of services.

Senator WILSON. Mr. Fleming, I was also heartened by your comment with respect to HCFA's intent to beef up nursing home quality assurance, and particularly in light of the observation with Dr. Moncrief has made, that it could use some beefing up because the nursing homes themselves in California have somewhat checkered record.

The problem that concerns me there is one that arises from some recent history. In 1982, California's State "Little Hoover Commission" with which I think you are acquainted, published a scathing critique of the State Health Departments Nursing Home quality assurance program. Both Medicare and Medicaid depended upon the same State personnel to ensure that the nursing homes met similar Federal standards. Yet, in the same year that HCFA gave to the State Health Department essentially a clean bill of health, the Little Hoover Commission to the contrary, gave them a failing grade in no uncertain terms.

The concern, I think, is obvious and that is why was there such an enormous discrepancy between HCFA's attitude and that of the Little Hoover Commission, and my specific concern that is relevant to the future rather than to the past, has to do with the intended

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implementation by HCFA this coming April of a new inspection system, when as I understand it, only about 300 of 2,000 State inspectors will have been trained in the new system.

What is HCFA's commitment to overseeing the State Agency Nursing Home Quality Assurance—Is the program really prepared for this rather significant change, this movement to the new system?

Mr. FLEMING. Our intentions are to increase our oversight of that and to provide the means for the State to increase its certification and review process.

As to what happened in the past, I can't answer that, Senator, because I am really not familiar with it, but I will get an answer for you and submit it to the record. I am not familiar with the discrepancy between the Little Hoover study and what HCFA had said. We will provide that for the record for you.

[Subsequent to the hearing, the following was received for the record:]

The HCFA evaluation of the State Agency covered all administrative, fiscal and operational aspects of the State licensing agency's work on behalf of the Medicare and Medicaid programs. While it is true that our 1983 evaluation found that the State licensing agency was, in general, performing its Medicare and Medicaid work satisfactorily, HCFA was critical of the State's performance in monitoring of continued compliance with health standards in participating facilities and in documenting the performance of providers with a history of being unable to maintain compliance with Federal regulations. The HCFA findings were, in this respect, consistent with findings of the "Little Hoover Commission."

It is true, however, that Medicare and Medicaid certification programs have focused on the process, rather than on the results, of patient care. This will change with the adoption of a new long term care survey process that is embodied in proposed regulations. The new long term care survey process is an outcome-oriented survey, rather than a process oriented survey. It focuses directly on the quality of patient care. HCFA intends to extend this type of survey to all types of facilities as soon as possible.

HCFA is fully prepared to implement the changes to its survey and inspection process by this April. Since 1978, we have been studying various modifications to the traditional survey process through Federally-authorized demonstrations and experiments in a number of States including a limited national implementation test concluded in March 1985. The new long-term care survey process synthesizes the best components of these demonstrations and experiments.

The objectives of the new process are twofold: To increase reliability and uniformity in the conduct of the survey and in the documentation of certification decisions; and to increase validity by emphasizing surveyor review of resident outcomes and provision of care rather than review of paper and structural requirements.

But we are committed to assuring quality care and, as I said, we will be focusing on patient outcomes. It is an emerging process and will evolve, obviously constrained somewhat by resources.

Ms. SKINNER. Senator Wilson, I would just like to say that I was a member——

Senator WILSON. Excuse me, Ms. Skinner, let me just make a point.

Ms. SKINNER. I am sorry.

Senator WILSON. Before we entertain your comment.

The point I am making is that this change is due to take place in April. That is not very far off, and if the personnel are not going to be a sufficient number and are not going to be adequately trained, it may be that that deadline is approaching too rapidly and you will have to choose another one.

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Mr. FLEMING. We will provide for the record the criteria and our plans for implementing that so you will have that.

[Subsequent to the hearing, the following was submitted for the record:]

In order to implement the new survey process and to ensure the quality of future long-term care surveyor training courses, a group of surveyors of varied disciplines, were chosen as instructors. Most of these surveyors had some familiarity with the new survey process either by participating in experiments or workgroups, or by conducting surveys during a limited national implementation test. These "core" instructors participated in a training course held in December especially designed for instructors during which they utilized the training materials to be used in future courses. This group of specially trained Federal and State personnel will be responsible for training additional surveyors in each State (up to 300), prior to implementation of the new survey process.

Once trained, these surveyors will, in turn, train the remaining surveyor contingent.

HCFA has also developed training materials to be contained in a training module on the long-term care survey process. This training module consists of three video tapes, a slide-tape presentation, a series of case study/slide training exercises, and an instructor's guide. The training materials will be incorporated as part of the Orientation Program for Newly Employed Surveyors and the Basic Course for Health Facility Surveyors, two highly successful current training programs.

Additionally, each regional office will develop a plan that includes detailed procedures on how it will work with each State survey agency in training all surveyors.

State survey agencies have been advised to conduct surveys using the new process only with surveyors who have been fully trained in the new process.

Senator WILSON. Thank you.

Ms. Skinner.

Ms. SKINNER. I was just going to say that I was a member of that task force that did the study and prepared the report, because at the time I was the chair of the State commission on aging.

The task force that worked on that, were a diverse group, they were probably the top people throughout the State in relation to health care for the aged. It was a very serious and a well documented project. That report was finished at least several years ago as you said. We had seen some improvement in care, but certainly there is still a desperate need for supervision and education, and for overall watch-dog capacity on somebody's part in relation to the care of the person in the nursing home.

Senator WILSON. Dr. Moncrief, you have stated, I think, very clearly and forcefully this morning what you feel to be the duty of the attending physician, to state whether or not the patient is ready for discharge. As a layman I cannot help but be impressed with the soundness of your argument and the clarity with which you stated it, and yet it appears that not all physicians have met your test. The other night I watched a special presentation called "Growing Older in America." Before my very eyes and the eyes of millions of viewers, a physician first hesitated when asked whether he had been pressured by the hospital to certify that the patient in that particular case was ready for discharge. Then moments later he reappeared after the announcer advised the audience that he had requested a subsequent interview and admitted that he had felt pressured.

Now, I don't know, whether to be blunt, he is a weak sister, whether there were tremendous pressures placed upon him by the particular hospital staff, and I am advised that hospital staffs can make life difficult for physicians, but it seems to me that you are

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right, that it is the obligation of the physician to his patient, first and foremost, to certify that the patient either is or is not ready for discharge.

I will concede that pressure obviously exists in the form of the system that we have moved to, and it seems that one clear thing from even the experience we have had to date, is that an average amount, based upon a set period of time, with respect to the hospital stay, does not take adequate account of obvious differences between patients. I may go to a hospital and it may be that I am even simply ill, but without serious complications and that under a particular DRG, 5 or 6 or 8 days is adequate for my treatment and I can then go home with no ill effect.

It may be that Mr. Schulke goes theoretically under the same DRG but in fact has all kinds of complications and at the end of the 8-day-stated period, he is not ready to go, he is still a sick man. To me it is unconscionable and I have been about as tight-fisted and loud mouthed on deficit reduction as anybody I know, I am even a little sick of hearing from me, but the fact of the matter is, it is unconscionable to me that a physician would say, gee whiz, the 8 days are up, he's got to go home, if in fact he is in no condition to go.

Now, it seems to me you are right, the obligation is that of a physician, but in sympathy with that physician, is it necessary to refine the system that is now in place by adding to it some kind of dimension that takes into account the severity of illness or complications which we have not adequately taken into account at the present time.

Dr. MONCRIEF. I think there is, Senator. There is no question that the DRG reimbursement rate is based on average. One patient might be hospitalized 8 or 9 days, and the DRG reimbursement is 7 days, but then there are a few patients that will only be in the hospital 3 or 4 days.

So, the reimbursement is on an average, but again, it has been proven time and time again, that there are gradations of severity of illness not included in the DRG and there should be some methodology of taking that into account, particularly in the so-called tertiary care institutions or the referral institutions where the sicker patients often end up.

It is my understanding that HCFA has projects that are looking at this with a way of spreading out the DRG's and recognizing the severity of illness. But I, certainly as a practicing physician and with responsibility to get patients out of the hospital, recognize that some are sicker. I would endorse HCFA's pursuit of the severity of illness component in the DRG.

Mr. FLEMING. We are looking at that. I believe there is one at John Hopkins. It is a study on the severity of illnesses that is being looked at.

I might add to this, too, that Dr. Moncrief and I were talking about this before the hearing began, what we are really seeing is a requirement under PPS to change years of behavior that in terms of Medicare, patterns of practice for physicians treating Medicare patients have been in place for almost 20 years before prospective payment came along.

Those patterns of practice are now being challenged because the incentives have changed. The system is now asking physicians and hospitals to begin to change the way they look at their practice of medicine. The old incentives that were in place were to not be concerned about costs, because essentially the reimbursement was on a cost plus or at least a cost basis. So the issue then was cash-flow and more cost simply represented more reimbursement. Prospective payment obviously has changed that and with that has come the requirement to begin to change the way we practice. It is very difficult to get people to quickly adapt to that kind of change. So part of what we are seeing is the normal process of professional men and women undergoing—the internalization of that changing process and the necessity to change attitudes along with that. It will come in time as do all changes.

Senator WILSON. That leads to a question as to when it will come.

Mr. FLEMING. Well, we think back to the conception of Medicare in 1965 and the medical community was so adamantly opposed to Medicare. It was an intrusion of the Federal Government into the practice of health care. There were bitter battles fought in Congress at that time, but gradually the medical profession adapted to that and it has become institutionalized in our practice of health care. We wouldn't even go back and re-argue and re-hash those arguments anymore. I believe as we evolve, everyone recognizes the need to make changes in the way we reimburse. The issue is in the mechanisms that we use and what the results are.

Senator WILSON. Mr. Fleming in the interest of time, let me interrupt you.

Would it be your judgment and, Dr. Moncrief, I would ask you as well, that there can be some adjustment of the DRG in a way that holds some promise of being largely revenue neutral.

There is an emphasis, I know, on increasing outpatient treatment in terms of utilization. I know too, that the effort is being made through the use of DRG's to strike an average that will allow the hospital to hopefully not suffer and may make a little on some patients and lose a little on others.

But there is a problem that I think we encounter, for example, in trying to balance the equities between skill and time in the case of a physician. A cataract operation presumably requires great skill. I gather than the art has advanced to the point where it no longer requires a great amount of time, thanks to new technologies. In comparison, the care of the elderly in more mundane ways, is enormously time consuming and not nearly as well compensated which is the question that leads to another question that I want to ask Dr. Moncrief about professional training and option.

But is there in your judgment some realistic hope that in addition to fine tuning the PPS system so as to provide for the flexibility that seems to lack now, and which seems to have entailed pressure, or created pressure for premature discharge, is there some realistic hope that we can also adjust the DRG's in a way that will be relatively revenue neutral, or are we looking at the absolute necessity for increased costs?

Mr. FLEMING. Senator, if the DRG system is the final word, I believe we have failed, that we will not be able to simply adjust inter-

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nally, and keep it revenue neutral because when you do something new, you have to give something else up somewhere else by definition.

Again, we see prospective payment as transitional and moving toward greater reliance on capitation. We have a number of demonstration projects in process right now involving the community at a greater extent in community based services dealing with long-term care, post acute care. We have, two, maybe four, social HMO demonstration projects under way. We see the hope and the optimism—the optimistic answer to your question—is we can accomplish those ends, it won't be done under DRG's, it will be done under a process of capitating these services.

Dr. MONCRIEF. I certainly agree, Senator, with Mr. Fleming. The PPS is a transition.

Senator WILSON. The entire subject of capitation is of great interest to me as it is to you. I think we ought to take another of your morning sometimes soon to discuss that.

Let me conclude this panel with a couple questions to Dr. Moncrief. We have taken a great deal of time with this panel because I think it has been extremely valuable.

Let me come back to the statements you made, Dr. Moncrief, about the treatment of the terminally ill. I think that is a critical problem, that is clear not only from the standpoint of the requirement for humane treatment, but we have an even more acute conflict there in terms of cost. I have forgotten what the statistic was the other night from the television special, but it struck me at the time that an incredibly large percentage of total Medicare expenditure relates to the final year of life, and in many instances, the final days of life of a number of Medicare patients.

You spoke earlier of the possibility of a terminally ill DRG. I am fascinated by that. How in the world would you construct such a thing? I mean if we are talking about difficult of making an actuarial average fit more conventional kinds of illness, how would you construct the terminally ill DRG?

Dr. MONCRIEF. There is no question, it is awfully complicated. I think that an easier approach to it would be to try and convince the long-term care community that it is appropriate for people to die in nursing homes. There is the hospice program and HCFA, and HHS, is supporting and expanding the hospice program. But I think we have an opportunity to make progress, I think, in educating the long-term care community that people can die in nursing homes. It is appropriate for them to die in nursing homes rather than this emergency move from a long-term care facility to an acute hospital and the necessity for admission.

Another way is to educate the physician to properly document the clinical record, because we are looking at these records retrospectively. I don't want to cheat the program with Mr. Fleming sitting here; I don't want to appear to be an advocate that I want to cheat the program, but we are looking at these things retrospectively. I think we have to educate the physician, the discharge planner, the social worker, and everybody into sufficiently documenting the need for acute hospital care in that patient.

I think that it is much better to improve documentation than to come up with a terminally ill DRG. And I have to say that my answer of the terminally ill DRG is a rather simplistic answer.

Senator WILSON. Dr. Moncrief, let me ask you whether the medical profession is providing a sufficient number of physicians who are specially trained to deal with the problems of the elderly?

Dr. MONCRIEF. You have an expert in this area, Dr. Barbaccia, who will come up on one of your subsequent panels, Senator Wilson, and I think he is much more atuned to identifying the resource needs for the geriatric community.

I would pass on that one if I may.

Senator WILSON. That is fine. You have been generous already.

Let me just ask one final question of you then, and we will put that question to Dr. Barbaccia, but let me just ask this one.

It was occasioned by not only Mr. Gould's testimony that it was a pediatrician who disagreed with his attending physician, but another instance of a similar kind. Do we have people making the evaluations who are adequately trained. It would seem that what we are talking about in the case of Medicare evaluation is a necessity for someone who is familiar with the disorders of the elderly.

Dr. MONCRIEF. It would be nice if in doing the review we could have the appropriate clinical specialist look at each case, but I would like to emphasize the fact that the majority of our review is done retrospectively, it is what is documented in the record. This happens so often—I myself am guilty of it—you have a patient that you follow for a long period of time, you know his complete medical history, you know he is only going to be in the hospital for a short period of time, and you shortchange the documentation.

So when that 2-day admission is looked at 3 months down the road, there is no sufficient documentation in there; the physician is keeping it in his mind, he doesn't put it in the chart. When that case is denied and on appeal additional information is furnished, the appeal is always reviewed by a board certified physician in which the specialty falls.

So while the first cut might be a generalist, might be a pediatrician looking at an orthopedic case or a neurosurgeon looking at a gynecological case, on appeal, the appeal is always heard by a board certified physician in the specialty in which it occurs.

In this instance, I think it is appropriate. Additional information was furnished, or the board certified physician looked at it and overturned the denial.

Senator WILSON. Thank you. I want to thank all the witnesses. You have been more than generous with your time.

I am reminded by Mr. Schulke that in extending thanks, I need to include the California Medical Association and California Hospital Association, not only for attending, but for providing written testimony for the record. I do wish to thank them as well.

Thank you very much. Since our subject is health, we are about to take a very brief health break. Please be back in your chairs at 11:30.

[Whereupon, a brief break was taken from 11:25 a.m. to 11:30 a.m.]

Senator WILSON. Ladies and gentlemen, take your seats please.

Our second panel this morning consists of representatives of the hospital, and we have two distinguished witnesses, Mr. Sam Tibbitts, president of the Lutheran Hospital Systems Corp. and Kendall Phelps, administrator of the French Hospital Health Plan. Mr. Tibbitts was trained at UCLA and the University of California at Berkeley. He has had a distinguished career in hospital administration which includes serving as the commissioner on the Joint Commission on Accreditation of Hospitals. He served as cochair of the national steering committee for the voluntary effort to contain health care costs, and is the past chairman of the American Hospital Association, the California Hospital Association and the Hospital Council of Southern California.

Mr. Tibbitts, we welcome you and apologize for detaining you so long. I think this is a valuable hearing and the record will prove extremely useful, so forgive us and with that, a warm welcome.

STATEMENT OF SAM TIBBITTS, PRESIDENT, LUTHERAN HOSPITAL SYSTEMS CORP., LOS ANGELES, CA

Mr. TIBBITTS. Thank you, Senator Wilson, it is a real pleasure to be here, and no apologies are necessary. I found the discussion very interesting.

I would like to capsulize in serial form my written statement that was submitted to you.

I would like to assure the committee first that the vast majority of hospitals in this country have responded very well to the prospective payment system. They have gone to a great deal of work, effort, monetary expense in instituting not only discharge planning, proper discharge planning for Medicare patients, but also admission planning, and we are doing more and more in terms of educating the elderly in what facilities, what services are available to them in the community.

Many of us are instituting so-called SHMO's, the social HMO's, which we call our senior health connection in the Lutheran Hospital society.

I think the hospitals have responded well and I can say that I agree with Mr. Fleming, and the studies of HCFA certainly show it, that at this time there has been no dimunition of quality of hospital service for the elderly under the prepayment system.

Again, I go back to Mr. Fleming's studies by HCFA. There are isolated cases as there always are, and you can find those with insurance cases, medical cases, all kinds of cases. But overall, care has been excellent.

I think the real concern before this committee is to address the components of a program of managed care under a prospective payment system, and the need to treat all providers alike.

Under the PPS, the incentives for hospitals were dramatically changed, a similar change was not made for home health, skilled nursing facilities or any intermediate care facilities. Today, patients are medically prepared for discharge, but in many instances, there does not appear to be a system of posthospital care sufficiently integrated with the acute care hospital to provide for a smooth transition.

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Additionally, Medicare's variant payment system, DRG based part A which is the acute hospital part, and fee for service, part B which is the physician's part, is an inherent obstacle to achieving optimum results in resource use.

Not only must providers of various forms of institutional and home care be treated alike if PPS is to be effective in the future, but a viable physician reimbursement system must be implemented which includes incentives that conform those of the hospital provider. At the very minimum we must encourage a level playing field among all providers under the Medicare prospective payment system.

Next, we believe the Federal Government must pay particular attention to the availability of SNF and intermediate care beds and take a hard look at States whose planning laws restrict the conversion of excess beds in acute care facilities, to more appropriate levels of care. The most economical way to provide SNF and ICF beds is through such conversion and not the building of free standing units.

In the area of PPS payment to hospitals, there is a great problem in working with national averages which provide damaging results to hospitals in high cost States such as New York and California. We believe this is definitely unfair and a better methodology must be developed.

An area of great concern is the disproportionate share of Medicaid and medically indigent persons who are served by certain hospitals, particularly in the inner cities and the rural areas. These hospitals must be given special monetary relief or quality care will become unavailable to these persons, which also include a significant segment of Medicare patients.

Regarding future approaches, I would like to make the following points. We are supportive of a fully capitated financing model, one that is inclusive of all provider segments—physicians, acute care hospitals, subacute care level facilities, and home health.

Our experience so far with Medicare recipient capitation within a number of our facilities, has been quite promising. We have found it to be a workable model for serving the full range of patient health care needs in a highly effective manner. A capitation method encourages the integration of provider services and, we feel, can result in better coordination of total patient care delivery.

Finally, in closing, in our opinion, the Medicare patient is presently being well served, but continued interference exercised by the Federal Government in terms of cost reduction and expanded quality assurance without recognizing the proper relationship between cost and quality will create a dichotomy of purpose for the providers of care and possibly a second class health system for our senior citizens.

Thank you, Senator, I will be happy to answer any questions.

[The prepared statement of Mr. Tibbitts follows:]

PREPARED STATEMENT BY SAMUEL J. TIBBITTS

As President of LHS Corp., a Los Angeles based multi-healthcare system, it is my pleasure to address some of the issues raised by the impact of the prospective payment system upon the healthcare provided to our Medicare beneficiaries. It is our understanding that concern has been expressed by the Senate Special Committee on

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Aging relative to the continued implementation of the prospective payment system. These concerns have focused on: (1) whether the post hospital care component of the medical care delivery system is prepared to receive patients now being discharged from hospitals earlier than in the recent past; and, (2) the degree to which patients are informed of their Medicare rights in this new environment.

Although these concerns are genuine and warrant continued investigation, we believe that the Committee does recognize that at this time there has been no diminuation in quality of hospital services provided to Medicare beneficiaries since the inauguration of the prospective payment system. We are all aware of anecdotes brought forward that would indicate specific circumstances where medical care has not been as desired; however, these have proven to be isolated instances where there have been problems in individual judgments. A study commissioned by HCFA supports, in fact, the understanding that no systematic problems exist, at this time, with the quality of hospital services and care provided under PPS. According to the Commission on Professional and Hospital Activities (CPHA) who performed the study for HCFA, Medicare's prospective pricing system in 1984 was effective in reducing inefficiencies in the care of Medicare patients without producing deterioration in the quality of care. Through comparison of patient data, CPHA found no significant changes between actual and projected readmission and mortality rates.

The concern before this Committee, therefore, stretches beyond the question of quality of hospital services and must necessarily address the components of a program of managed care under a prospective payment system. As we all know, under prospective payment, the incentives for hospitals were dramatically changed. A similar change was not made for home health, skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). Basically, patients are medically prepared for discharge but in many instances there does not appear to be a system of post hospital care sufficiently integrated with the acute care hospital to provide for a smooth transition.

The fragmentation of the healthcare delivery system is clearly the cause of many of the difficulties that have occurred. To the extent that the system becomes more vertically integrated with hospitals, skilled nursing facilities and home health agencies operated under one corporate umbrella, we will see better opportunities for more careful management of patient care through the entire spectrum of services that an individual might need. The problems with the current fragmented system are further exacerbated by regulatory agencies such that there currently exists a discontinuity between what technology allows for, the reimbursement system calls for, and the availability of appropriate facilities.

A pertinent example is the lack of availability and accessibility of SNF and ICF beds in many communities. It is a commonly held view that some state Medicaid agencies are restricting, through either certificate of need or other regulatory programs, the number of SNF or ICF beds in their states as a way to control Medicaid expenditures. The conventional wisdom is that once a nursing home bed is built it is filled, and fifty per cent of the time it is filled with a Medicaid patient. Therefore, some states have latched on to a limitation of SNF and ICF beds as one of the easiest ways to control state Medicaid financing.

As a provider operating in the prospective payment environment, we have realized difficulties in effecting the timely transfer of hospital patients to skilled nursing, intermediate and custodial care facilities. In Los Angeles County, ICF beds are virtually nonexistent and SNF beds are extremely tight. Further, the selectivity of available facilities compounds the problem of accessibility. There are often long delays in finding an appropriate facility to accept elderly patients with extensive sub-acute care needs, as well as those requiring long term periods of care.

In California the lack of availability of SNF and ICF beds has been recognized, although immediate solutions continue to be debated among industry factions. The 1990 State Health Plan has officially recognized the demand for SNF and ICF beds and through easing of the Certificate of Need (CON) process, additional capacity has been encouraged. (California CON covers SNFs through 1987.) The construction of additional SNF and ICF capacity, however, would appear to be only a partial solution, especially in light of the current state of excess capacity of acute care beds. A preferable and perhaps more parsimonious approach is to encourage, through existing CON laws, the "resizing" of existing acute care facilities prior to the construction of new skilled nursing or intermediate care facilities. Excess capacity in the form of available acute care hospital beds should more liberally be converted to other uses. Federal agencies concerned with re-integrating the spectrum of services that a Medicare beneficiary might need should take the steps necessary to ascertain that State CON laws are not unnecessarily restrictive in the conversion of excess acute care capacity to ICFs and SNFs.

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As a provider of hospital services, we also encounter Medicare patients requiring SNF level care who are unqualified for SNF reimbursement because of the three day prior hospitalization requirement. These situations frequently result in medically unwarranted use of the acute care hospital. We recognize the difficulty in repealing the three day prior hospitalization requirement, in that such a repeal probably would change the nature of the Medicare SNF benefit. Medicare is an acute care program. The SNF portion of that program was envisioned as a follow up to acute care in the hospital. The fear has been that if the three day prior hospitalization requirement was removed, the door would be open for more of the traditional long-term care services to be financed under Medicare.

Yet, we need to reconcile this troublesome benefit expansion with beneficiaries' medically unwarranted use of the acute care hospital. From both a financial and quality perspective we urge the continued evaluation of methods to encourage appropriate designation and payment for sub-acute levels of care.

In the two years following the implementation of Medicare's prospective payment system, hospitals have frequently come under an erroneous attack of prematurely discharging patients as a cost saving measure. This, we feel, is an inappropriate accusation. We recognize that as of this time not all hospitals have developed the same degree of sophistication with discharge planning, but we believe strongly that the vast majority do have highly qualified discharge planners and the talents and success of these departments are improving on a daily basis. These departments work with patients, physicians, home health agencies and nursing homes to assure that the transition from the acute care environment to a post acute care setting is accomplished with a minimum of disruption and with the patients fully informed as to what is occurring.

We firmly believe that both physicians and the hospital management team have a responsibility to inform patients as to what is happening to them under the prospective payment system. Although it might seem easy to blame a discharge on Medicare, responsible medical professionals need to be honest with their patients as to why each discharge is medically appropriate. I truthfully believe that our hospitals are living up to these responsibilities.

Within our own hospitals we have implemented a number of measures to assure the appropriate utilization and management of acute care services. These measures are in tandum with an ongoing patient education and case management process. One must recognize, however, that in the state of California, prospective payment is pervasive; payment is affecting HMOs, Blue Cross/Blue Shield and Medical patients in addition to Medicare beneficiaries. As a result, our efforts and programs of utilization management cut across all patients in a similar fashion irrespective of their source of payment.

It is my understanding that some people believe hospitals only do those things they are required to do in order to meet the objectives of their local peer review organization (PRO). The PRO in the state of California, CMRI, consistent with Federal guidelines, performs a 100% review of any patient readmitted within seven days from discharge. Hospitals affiliated with the LHS healthcare system, however, have quality assurance programs that are far more sophisticated and involve far more in-depth analysis of actual patient care than those mandated by the PROs.

For example, we have expanded the scope of our admitting process to comprise the collection of extensive patient information that identifies the appropriateness of acute hospitalization, questionable patterns of hospital readmission, and potential patient discharge planning needs. In cases where multiple acute care admissions are present, hospital-based social workers assess the sufficiency of the patient's home health environment and work with the patient, family and outside health agencies to optimize the health quality of the patient's lifestyle. The admission procedure also encompasses a confirmation to the patient of the expected length of stay based on information furnished by the attending physician.

We have also adopted a more integrated approach to the quality assurance and utilization review functions using Diagnosis Related Group (DRG) methodology to monitor services rendered on a case-by-case basis. In conjunction with hospital administration, physician advisors monitor quality of practice and utilization. We focus equally on parameters of underutilization as well as overutilization. Both individual cases and patterns of practice that reflect indeterminable quality or utilization are referred to executive medical staff committees for review and appropriate action. This data then becomes a component in the physician credentialling process. While we have noted the growing participation and cooperation of the medical staffs with the hospitals, we feel that Medicare's variant payment system for these groups (DRG based Part A in-patient hospital services and fee-for-service based Part B physician services) has established an inherent obstacle to achieving optimum results in

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resource use. Compounding these payment inequities is the physician malpractice crisis, which provides a strong disincentive to the practice of cost-efficient medicine. We believe that a viable physician reimbursement system must include incentives that conform to those of the hospital provider. At a very minimum, we must encourage a level playing field between hospital and physician providers under the Medicare prospective payment system. Competing incentives will not serve to the benefit of any participant under the PPS program—especially the patient. We also believe that not only the hospital, but health providers and insurers as well, need to share in the responsibility to support the availability of a complete continuum of care for the beneficiary, in contrast to what has traditionally been a segmented network.

There are other factors concerning our experience under the prospective payment system that I would like to bring to the attention of the Committee. As a transitional approach we find that the prospective payment system has been effective in reducing inefficiencies in the care of Medicare patients. There are, however, a number of side effects, especially pertaining to the level of payment and treatment of hospitals caring for a disproportionate share of the medically indigent.

Our hospitals are non-profit organizations whose mission it is to care for the healthcare needs of its community. Communities are unique not only by their incidence and prevalence of disease, but by their social-economic standing and ability to incur the costs of needed healthcare services. It would be naive to believe that communities can be "blended" across the country into one homogeneous group. America's "melting pot" today represents a conglomeration rather than a pure blending of individual and distinctive communities. Because hospitals address the health needs of distinctive community segments, payment to hospitals, rather than a single national rate, should recognize individual and unique attributes. This is especially critical for urban hospitals serving a disproportionate share of medically indigent patients.

Even in light of the relative success of the PPS system to date, there are a number of fundamental issues which remain unresolved. The legal, ethical and financial problems involved in the resource intensive healthcare of chronically and terminally ill patients; long term skilled nursing, intermediate and custodial care reimbursement responsibilities; and accountabilities for the provision of indigent care, are basic considerations that need to be addressed at the level of national policy and guidelines if we are to attain a truly effective system.

I would like to make a couple of points regarding the future. As a provider system, we have had the opportunity to examine several new approaches for the future of healthcare financing, particularly those involving the Medicare program. We are supportive of a fully capitated financing model; one that is inclusive of all provider segments—physician, acute care hospital, sub-acute care level facilities and home health. Our experience with Medicare recipient capitation within a number of our facilities, has been quite promising. We have found it to be a workable model for serving the full range of patient healthcare needs in a highly effective manner. A capitation method encourages the integration of provider services and, we feel, can result in better coordination of total patient care delivery.

Finally, in our opinion, the Medicare patient is presently being well served, but continued interference exercised by the Federal Government in terms of cost reduction and expanded quality assurance without recognizing the proper relationship between cost and quality of care will create a dichotomy of purpose for the providers of care and possibly a second class health system for our senior citizens.

Senator WILSON. Thank you very much, Mr. Tibbitts.

Mr. Kendall Phelps is the administrator of the French Hospital health plan, a health maintenance organization in San Francisco. We are very grateful and delighted to have him with us this morning. His particular perspective will be the impact of the PPS system on the functioning of health maintenance organizations.

STATEMENT OF KENDALL PHELPS, ADMINISTRATOR, FRENCH HEALTH PLAN, SAN FRANCISCO, CA

Mr. PHELPS. I think from the standpoint of the health maintenance organization we have a slightly different perspective, Senator. We receive, as you know, capitation, and we have the things that Mr. Tibbits wants. We have a totally capitated system where we are responsible for all levels of care, so that we have some of

the things that you are looking to build within the HMO system. Since we have such great expectations for this program and the demand, or the enthusiasm in the Medicare recipient community has been so great, it seems to me it would be important to take a look at what protections you have now and what things you should be thinking about in the future to make certain that the care is of high quality and people are not abused, are not taken advantage of.

Second, I would like to discuss why premature discharge is not a big problem in the HMO area.

The reason I want to go into this is because there is some suggestion that to accelerate the capitation of physicians, we would move into a voucher systems or systems where a group practice or other kinds of physicians could get a contract with the Government that would be a cost saving on an immediate kind of a basis, but I want to caution against that and I want to go through some of the things that you are protected by now.

All HMO's, to get a contract with the Government, must be a HMO or a competitive medical plan. These are highly regulated organizations. I do think though, that HMO's have a lot of emphasis to getting a license or the right to be called an HMO, but they don't have enough money to go out and do a lot of field work and I think something should be done about that, they should have more opportunity to do field work.

Medicare risk programs like the ones that we are talking about, are required to have 5,000 members in other than Medicare members. I think this is an important consideration as it prevents an organization from being formed to take advantage of the Medicare only. Pressure will come to drop this because many hospitals have said that it prevents them as a hospital from getting into that business. I think it is important to keep it because that ordinarily means that the organization must have a State license and there is a fair amount of quality care and monitoring by—certainly in California—State licensing under the Department of Corporations.

But in any attempt to broaden the range of eligible organizations was they don't have licenses, I think is scary, and those of us who were here in California in the 1970's when we had an attempt in the State Medicaid Program, MediCal, to solve that problem in a hurried way, will remember the abuses that occurred there. That could happen in Medicare as well.

Also, regional HCFA has begun a monitoring program on some of the things we call quality. Now, I agree with Dr. Moncrief that only a physician can deal with the fine points of quality of care. But to the elderly, when they look at quality of care, they look for other things. They look at access, how you were treated, whether you could get to the right place at the right time and those kind of things. They are being monitored by the regional office of HCFA.

One of the things that the HMO has that the hospital does not, is the incentive to be careful about this premature discharge. I don't think it is as big a problem as people are making it, but I thought I would take the time to point that under HMO, we have no incentive, as the hospital does, for the money they get from the readmission. If you send somebody out early from a hospital under the DRG program, the PPS program, and then comes back in a few

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weeks, the hospital is paid twice. To an HMO they don't get paid twice, they get paid only once, a monthly fee and that is independent of whether the people are sick.

So the HMO, and in particular programs like Mr. Tibbitts' program and ours, we are forced by circumstance to set up a system to coordinate appropriate level care for the high-risk elderly who enroll in the program. We provide case managers who are skilled in the affairs of the elderly to make certain that their way is smooth in the health-care system so they get the most appropriate care.

We have some other problems to look at when we encourage people to join HMO's; one of them is denial of care. You can always monitor care if it has been given, and you can look at the hospital chart and see if this was appropriate or wasn't appropriate. What is harder to monitor is care that may have been appropriate but not given at all. I am talking about your interoccular lens implants, for example. If you put the HMO risk for the cataract surgery, will they be done in an appropriate way, or will people who deserve them, not get them? Will people who may require hip replacements, complex costly surgery, be deferred to a point where it would be inappropriate care? Those are very difficult things to monitor and setting up a mechanism to do that will be costly and require an awful lot of thought. I personally don't know how you start to develop a system that has to monitor that.

In conclusion of my remarks, I want to make certain that you knew that the HMO and the capitated system addresses many of the issues that the PPS system raises, but it also opens a number of other issues which are equally as important and as difficult.

[The prepared statement of Mr. Phelps follows:]

PREPARED STATEMENT OF KENDALL PHELPS

The recent availability of HMOs to Medicare recipients has changed the nature of care to that population forever. At present only a small percentage of the elderly are enrolled in HMOs, but acceptance by them has been high. As more plans are made available, and many licensed health plans are planning to offer Medicare options, the percentage will increase.

Many experts predict that nearly half of the entire population will receive care through an HMO or other managed systems by the year 2000. There is no reason to believe that the experience will be different for the elderly. Most of the new HMOs for the elderly are at risk; that is HCFA pays the plan a fixed sum per month per member; this sum is arrived at by a complex calculation but essentially it is 95% of what HCFA thinks they would have spent under the current system of reimbursement. The amount paid to the HMO is not related to the medical condition of any member. The HMO must offer additional benefits to the member; for instance, our program offers outpatient prescription drugs at nominal copayment; outpatient drugs are not a Medicare benefit. The degree of extra benefits varies, but all plans include co-insurance and annual Medicare deductibles.

Now with the expectation that one-half of the Medicare population will be served by HMOs, what provisions have been made to make certain that the care is of high quality?

First: All contractors must be either a federally qualified HMO, or a comprehensive medical plan; both of which are overseen by the Office of Health Maintenance Organizations; a federal agency. This organization requires a comprehensive review process, which includes on-site review of quality assurance programs and procedures. They also require periodic reporting of financial data, to protect the members from sudden insolvency.

Second. The Medicare Risk Programs can only be given to organizations that have 5,000 members in other than Medicare programs. This is a very important provision, as it means only those organizations who have on going programs, and for the

most part a state license to operate a prepaid program. In other words, the programs are not put together quickly for the purposes of exploiting the Medicare population. State licensure, particularly in California, means that an additional regulatory agency is monitoring the quality of care given in the program. The Department of Corporations of California actually does field audits of medical charts, and interviews physicians associated with the Plan. Also, they control the content of advertising material.

Any attempt to broaden the range of organizations, such as PPo's or organizations who may qualify under a "voucher" program would be a mistake, for these organizations go unregulated at the state level, and would also fall outside the authority of OHMO. For those who watched the abuses in the early 70's in California, the thought of allowing an unregulated approach to Medicare enrollment is frightening.

Third. Regional HCFA has authority to monitor many aspects of what we call quality care, such as access, grievance and complaint procedures, and so on. They are just beginning to develop this role, but the protocols for audit I have seen are excellent.

Fourth. Early discharge is unlikely in an HMO setting. The HMO, unlike a hospital, has no real reason to gain thru early discharge, as they must provide skilled nursing, home care, and are paid no more if a re-admission is required. This fact is often overlooked, and critics of HMOs seldom see the HMO's interest is to prevent rehospitalizations.

In fact, HMOs who serve the Medicare population are by circumstance required to provide a case management system for the frail elderly who enroll in their program. A case management program is a way of identifying and giving special attention to members who are frail, chronically ill, or who are likely to use inappropriate health resources. Our own program is extensive, utilizing four geriatric nurse practitioners who intervene to make certain that the members assigned to them have appropriate access to the health care system. Approximately 500 of 4,000 of our members are monitored in this way. Left to their own devices, we believe that these individuals would utilize many more resources than necessary, and would be much worse off. The response to the program by the members has been excellent, for a very sick elderly member now can call the case manager if they are having a problem with the pharmacy, transportation to see the doctor, or any other problem associated with the delivery of care. All observers who see this program are impressed with the quality of care being given to these individuals. It is important to note here that it is in our, the HMO's, best interest to provide this service, as we have noted a dramatic reduction in hospital utilization of this group of manage members in the last year.

The problem of inappropriate and early discharge under the PPS System can be monitored with existing systems, but it is still a monitoring system. The result obtained from such a system can never be as optimal as one where the providers and the members work toward the same goal, and the financial incentives are congruent with the goal of quality care in the most appropriate setting.

I ask the Committee to continue to support HMO development and expansion, as it provides the lowest cost to the government as well as the member. Extra benefits to the elderly in a managed system with appropriate utilization and high quality care are consistent, congruent objectives.

Senator WILSON. Thank you very much, Mr. Phelps.

Mr. Tibbitts, what in your judgment needs to be done to prevent some of the specific concerns that you heard discussed with the first panel that focuses on premature discharge, on informing Medicare patients of their rights of the appeal process on a denial. You have been sitting here, I won't rehash it. I would be interested in your view from the standpoint of the hospital administrator.

Mr. TIBBITTS. Well, as I mentioned to you, Senator, the hospitals are already educating the patient through the SHMO's, I am not so sure we should be liable for that expense. The Federal Government set up this program and it seems to me the Federal Government should be educating the recipients, and I would like to see HCFA do more in providing educational programs, pamphlets, what have you. We would be most happy to provide facilities for those educational programs, most hospitals would. We would be most happy to

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distribute those pamphlets to the patients and to better educate them.

As to early discharge, I think we are always going to have some problem in medical practice, in hospital practice with all types of patients where the patient may feel he was discharged too early. It usually boils down to the case where the patient has no place to go. The patient has no home to go to, the patient is not eligible for a skilled nursing facility, you cannot give home health care if a patient has no home. I think that is a societal problem that we are going to have to discuss fully.

I would hope that the committee would take some time to really look at this medically indigent problem. I think it is the most serious problem we have facing us in the United States in health care. I don't know who is going to pay for all of the medically indigent persons who are uncovered by Medicare or Medicaid in the future. As the hospitals are being squeezed out through the reimbursement, through competitive models, through pricing policy, the hospitals in California, particularly are in trouble on this subject because now we cannot overcharge the private paying patient or the insurance patient, because now they have the ability to come to us and say, we want your best rate. There is no such thing in California today as hospital charges. We negotiate a rate with insurance carriers, PPO's, HMO's, Medicare, MediCal and basically it is very close to cost, and so we no longer can "cost shift" as we were accused of for many years. We can't shift our losses on Medicare and MediCal to the insurance carrier.

So, who is going then to pay for these poor medically indigent people who have no coverage? I think it is a societal problem, it is not a hospital problem although we are involved, it is not a physician problem, it is a total society problem that has to be led by somebody in its solution. To me it is a greater problem than the PPS system that maybe has some early discharges. In 5 years we will have a serious situation.

Senator WILSON. One proposal that has been advanced and I guess actually employed in certain States, has been that of the pooling of funds. Do you care to comment on that?

Mr. TIBBITTS. That has been tried in Florida. That has possibilities. I am not saying it is the best solution to this problem. I think we all have to work together—providers, Government, business—all of society, in determining who should put forth so much money for that particular situation. To me since it is a societal problem, most of it has to be Government money, however, if you Senators don't change the tax laws too much, we may have enough philanthropy left to help with the situation. I think we would be happy to step up our philanthropic fundraising efforts to help out in serving these medically indigent people.

I think there are a lot of sources of revenue that have to be used in solving the problem.

Senator WILSON. I wish I could be optimistic in response to your comment, but I am reminded of New York Surrogate Court case opinions in the 1880's that run something to the effect that no man's life, liberty, or property is safe while the legislature is in session. Which means that the Republic is safe until the 21st.

The problem that you have focused on with respect to the homeless and medically indigent, I quite agree is a problem that is enormous, and the fact that the committee has had at least one hearing that I am aware of, and I am sure we will have others. One specific point that we are interested in because a legislative proposal that may germinate into a bill, is going to eliminate the three day hospitalization requirement, the requirement for eligibility for a skilled nursing facility.

Would you support its elimination?

Mr. TIBBITTS. Yes; I would support its elimination providing that we have the assurance that this won't be abused. Now, how you get that assurance is another question. I think we have a tendency in making the laws to look at everybody as being a crook and maybe only 2 percent of us are, and we, therefore, try to cover 100 percent of the people with our regulations when we only have to cover 2 percent. I would, therefore, be in favor of eliminating the 3-day rule because I think we could save a lot of money by moving the patient into the SNF's and into home health service.

If we have the SNF's available, the SNF beds, and the intermediate care beds, I think we have to take a better look at intermediate care which could save even more money.

Senator WILSON. Would it be a fair inference, fair characterization of your testimony, particularly that portion that related to conversion of some surplus or excess acute care beds to nonacute care, would it be fair to say that you are really suggesting that in many instances existing hospitals not now operating on the model of the HMO, increasingly convert to that modality?

Mr. TIBBITTS. Yes; there are a lot of excess beds in the country today, and they can be converted very easily to SNF or intermediate care beds with very little cost.

Senator WILSON. And in for-profit hospitals situation, you would see a number of hospitals able to do that and you think willing?

Mr. TIBBITTS. I can't speak for the profitmaking hospitals, I can speak for the not for-profit hospitals, and, yes, they are very willing. I don't really understand why the profit hospitals wouldn't be willing.

Senator WILSON. Some emphasis has been placed this morning by the preceding panel on the necessity of the proper setting for the education of the patient. I think it was a fair consensus that preadmission was the time to conduct that education and by the time they are actually in the admission office, it is too late, there are too many distractions, the patient is not likely to grasp his or her rights.

Would you concur in that?

Mr. TIBBITTS. I would concur to a certain extent. We do still have patient relatives who we can explain these things to, and we do. It would be very nice if we could educate the elderly and all patients as to what the restrictions are and their insurance policies on Medicare, before they came into the hospitals so they would have a better understanding.

The problem is, as with most education, people forget very easily and they are really not concerned until they actually have to go to the hospital. Here again we come back to the bulk of us recommending a capitated system. I think the HMO probably does the

education better, and it leaves the patient in better shape because the patient does not have obligations in terms of payment for hospital care, or physician care, and the total program by HMO's is totally integrated. Home health, drugs, surgical care, outpatient surgical care.

Again, that is why we recommend and integrated system, and I guess what we are really saying is a corporate model where we have the precare, ambulatory care, the hospital, the SNF, the intermediate care, the home health care, under one umbrella so we can integrate properly.

Now, I am not talking about hiring physicians please, I don't believe in hiring physicians, but we do have arrangements. We contract with physicians to provide service, and you still get that integrated health care system. That is what we need, I think, to solve this problem or most of the problem.

Senator WILSON. Mr. Phelps, how can peer review organizations improve their review of the health maintenance organizations handling of their Medicare patients?

Mr. PHELPS. I think that it is first the choice of what to use, which organization to use, to monitor the HMO. At the moment the PRO is being looked at as the best organization to review the HMO. I am not certain that it is the appropriate organization in all cases.

In many of our States the PRO—certainly not here—I think our organization is a very independent outfit—but in many places the PRO is an adjunct of medical society organizations. Many of them were formed by the doctors with the explicit purpose of protecting the fee for service environment. They want to protect that and have every right to do that, but to have these organizations who with that stated purpose in mind review a closed panel system with which they have had many arguments over the years, would be poor. I think that would be a poor choice.

There have been a couple of organizations advanced—by our own trade association, group health group association, to be the organization to monitor HMO's. These should be considered. I think the first thing is to decide who should do it.

Second, I think monitoring ambulatory care requires a sophistication of a different kind than hospital care. In hospital care, the people are there, you go look at them, you look at their record, but as I said earlier, it would require a more comprehensive systems approach to look at ambulatory care. I mean using computers and some kind of criteria that would allow the massive amount of data to be sifted through to make some intelligent determination.

Even in a small health plan you have Medicare members visit the plan 10 times or 12 times a year. There are 2½ million beneficiaries in California. It doesn't take very long to see that trying to monitor the care of each one of those visits is a massive job.

I think you have to first decide who should do it and, second, I think you should try to support the development of some kind of computer systems or reporting systems that will allow you to do analyses, and find something in to look at.

Senator WILSON. You are talking about two problems. One is technological if I understand you.

Mr. PHELPS. Yes, I think that is correct. You can monitor hospital care, we have all learned how to do that with PRO, chart review and so on. How do you monitor the care that goes on in a physician's office?

Senator WILSON. Mr. Phelps, do you see any reason for PRO utilization review or cost control review being conducted on HMO's?

Mr. PHELPS. Well, I think the incentives have changed by giving the HMO its capitation, and the cost control notion that PRO has, I mean its responsibility in that regard, is unnecessary. I think the Government resolved that. I think it formed the PRO to try to monitor the environment that was a fee for service, cost based, environment.

When you alter those incentives by giving the people the capitation, there is no requirement for having them monitor the cost or the necessity of the service. You have the additional responsibility of whether the quality of that service was appropriate. I believe a recent HCFA memorandum took them out of the cost monitoring just a few weeks ago—a week.

Senator WILSON. Let me play the devil's advocate. You are making the argument that under capitation you are going to receive the same amount, and you don't have the same incentive that the non-HMO hospital does. Some might argue that because you receive that set amount each month, regardless of what happens, that you've got an incentive to under serve, to try to cut corners.

Mr. PHELPS. I think that is a genuine concern, Senator. That is what I was alluding to earlier, that there are some issues, like premature discharges, which are not the problem. But prepayment raised some other problems. For instance, I mentioned total hip replacement can be very costly service to give to someone, and that could be deferred by the HMO. Say a person who is 95 and they think that they may have a few months to live, a cataract operation, lens implant, they may defer that. There is a whole host of problems that you buy with the capitation program. I am not saying it shouldn't be regulated, I am just saying it is a much more complex job to regulate it from a quality standpoint.

If you are talking about services that aren't being provided rather than hospital work that can be easily overseen. You have to look into the doctor's office, you have to get these records to see whether the people are getting that service.

So, it is much more complicated is all I am saying. I am not saying that it doesn't have to be done.

Senator WILSON. So what you are saying is you think there should be a review, you are not certain that existing PRO's are the ideal——

Mr. PHELPS. I am not sure that they have the tool, and I am not sure that we have the real technology to look at it. I think in a very sophisticated way you can go in and look at doctors offices and say, well, maybe—How are you going to know whether the hip surgery was deferred to beyond a point that a person could have been helped. Who will know?

Senator WILSON. I don't know. That is a very good question. It seems to me that really what we have been talking about this morning has to do not with elective procedures, but with the diffi-

culties that we have encountered in treating elderly patients who are clearly in need of treatment, and that is fairly difficult enough.

Mr. PHELPS. If the people are clearly in need of treatment, I am in agreement with Mr. Tibbitts, that 98 percent of the people will get it. These are professional health care people, they are going to take care of those people that are in need of treatment. They stand in your door demanding to be taken care of. It is in the elective area where the corners can be cut, not in the urgent treatment of people.

As I said, the premature of discharge is not a big problem with the HMO environment because the HMO's are responsible for paying for the home care, they are responsible for paying for the SNF care. If the patient deteriorates because of a premature discharge and they return to the acute facility, they don't get any more money. So there is a big incentive to have that care coordinated then in the most appropriate setting, one of the few times when what is appropriate in terms of quality of care, and cost are congruent.

Senator WILSON. Gentlemen, thank you very much. We appreciate your being here this morning and submitting not just thoughtful written testimony, but taking the time to be here in person and answering questions.

I will ask our third panel now to come to the witness table.

Our third panel consists of Dr. Joseph Barbaccia, Dr. Robert Reid, Ms. Patricia Worthen, and Ms. Sharon Grigsby.

Dr. Barbaccia is the chair of geriatrics in the Family Medicine Teaching Group at the University of California at San Francisco. He is professor and vice chairman of the Division of Family and Community Medicine at the University, and chairman of the California Medical Association Task Force on Health Care Issues of Aging Californians.

We are delighted to have you with us. I can understand why Dr. Moncrief wanted me to defer the question to you, and I will eagerly await the opportunity to do so, but we welcome you and invite your testimony.

STATEMENT OF JOSEPH BARBACCIA, M.D., SPECIALIST IN GERIATRIC CARE, UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO MEDICAL SCHOOL

Dr. BARBACCIA. Thank you, Senator Wilson.

I am honored and pleased to be here today.

Obviously, in all of our discussions, our concern has been with controlling high costs of hospital care while maintaining quality.

Because the cost of hospital care is so high, a number of mechanisms have been considered to decrease hospital use by substituting other levels of care when possible. For example, we have talked about the fact that the HMO, the health maintenance organization, avoids the use of hospital care whenever possible by substituting outpatient care. Yet it is important to keep in mind that when Medicare was enacted in 1965, the desired effect of government payment for medical care for the elderly, was to increase access to all the elderly in the United States, regardless of their ability to pay. Unfortunately, Medicare provided many financial incentives

to use the acute hospital as a place of care over alternate settings such as the outpatient department, the skilled nursing facility, or the home of the patient.

Currently, about two-thirds of the money paid out for Medicare beneficiaries for their care, are for acute hospital care even though the length of stay in each hospital admission has been decreasing progressively. Obviously voluntary and mandatory reasons of efficiency, have not reduced hospital care cost nor the portion of dollars paid for hospital care.

A Medicare prospective payment system for hospital care seemed a very promising way to limit hospital costs. Fiscal incentives for hospitals to limit the number of days of hospital care and hospital expenditures, were seen as the only way to finally control the amount of money paid out to hospitals. Under this system, obviously, hospitals are interested in receiving as much money as possible for any one patient, spending as little as possible in providing care, and having the patient stay for as few days as possible.

We have heard also about the utilization control and quality monitoring mechanisms already in place. The monitoring of medical necessity of admission to hospitals as well as the appropriateness of continued stay, is the responsibility at the hospital level of the utilization review team. The hospital and the medical staff are responsible for monitoring the quality of care provided by physicians as well as other health care personnel. Hospitals and physicians are in turn monitored by the PRO and the Medicare fiscal intermediary also monitor the provision of services by specific hospitals in admitting physicians. The aim is again to control utilization of hospital care without compromising quality.

Whether the quality of care has been compromised or not, really remains an open question as we have discussed today.

Under this PPS system, there is no question in my mind that patients who get into hospitals are sicker when admitted and are more likely to be disabled and dependent when they leave the hospital than prior to the establishment of the PPS system.

When such patients arrive at the nursing home, they need more nursing and medical care. When they arrive home after hospital, they need more in home service than was the case before PPS.

Yet the irony of the situation is that because of the overall emphasis to control all Medicare costs, even though in home services and S&S services are ordered by physicians for these sick patients, fiscal intermediaries are currently not likely to authorize the number of services requested and are likely to retroactively deny payment of services provided by in home service agencies. This has been my experience in San Francisco since I personally looked into the situation, currently faced by the VNA of San Francisco, our largest in home service agency.

Additionally, there is no question in my mind that physicians are pressured by hospital utilization review teams to discharge patients when all that can be done medically for patients in the acute hospital, has been completed and before patients are as independent in self care as they might have been if a more prolonged period of convalescent was possible in hospitals.

As one would expect, the patients who cannot care for themselves, who have an elderly or disabled or no spouse or family to

care for them at all, and who need intense personal care not paid for by Medicare, but do not need acute hospital care, are the patients who are most difficult to move out of hospitals. Obviously these patients are major burdens on their families and informal support systems if they exist. They can also place a significant burden on community agencies, especially if the patient and/or family find it difficult to pay out of pocket expenses for in home services, and for long-term care.

At this point, I would agree that it is impossible to know the number of patients who have died because of too early discharge from hospitals, or from the lack of proper care. My own experience is that few serious problems have occurred as a result of these pressures and situations, yet the possibility, for example, of future legal problems that we haven't even encountered yet, are present, especially in places like California.

There are several suggestions that I would make that could limit the impact of early hospital discharge, as well as to serve any complications that might result from premature discharge from hospitals.

But before I do that, I think we have to all understand and keep in mind: Medicare beneficiaries, families, physicians, health care workers, politicians, the body politic Medicare is a payment mechanism for acute medical and rehabilitative care. It is not designed to meet social needs, personal care needs and long-term care needs of beneficiaries.

We all realize, too, that the United States is in desperate need of a long-term care plan, especially for the middle class—the nondestitute, the nonwealthy.

Second, Medicare has been too oriented to hospital care, it must now provide financial incentives for outpatients and in home care while carefully examining better ways than repeated hospitalization and rehospitalization for providing an intense level of care required by severely ill patients, especially in their last 6 months of life.

In respect to the efficient use of the acute hospital, more careful discharge planning must be done by discharge planners as we have discussed. This has to be done in cooperation and corroboration with physicians, families and community agencies. Discharge planning must begin as soon as the patient is admitted to the hospital or before, if possible. Some physicians can no longer remain aloof on the discharge planning process by delegating it totally to others, or by remaining uncooperative. Discharge planning must be considered the business of the hospital and the physician and not taken as an interferences in the doctor-patient relationship.

The patient care review and quality review committees, the medical staff in hospitals, must monitor too short hospital stays and the instances of a rapid readmission, that is, within 24 hours or 15 days after discharge, so that the problems brought about by too early discharge can be dealt with at the hospital level, to determine whether they are a result of physicians orders, pressure from the UR team, inadequate discharge planning, inadequate or inappropriate in home services, or for purely social reasons. The PRO must also carefully review hospital performance when these situations are noted or when anticipated complications or death occur.

Additionally, it is well recognized that payment to hospitals for some DRG categories is inadequate. Some patients who are very severely ill and required complicated care, are not paid for adequately. The PPS commission which periodically adjusts payment, should look into these cases as quickly as possible.

Finally, hospitals should consider the establishment of "step-down" beds for patients who need the hospital environment for adequate, early convalescence that could not be conveniently nor safely provided elsewhere. The cost of such care would be less than in the usual hospital bed certainly.

One last thought. As the number of very old persons, that is persons 85 years and over increase in the American population, the health care system and policymakers need to carefully rethink ways to change from our over dependence on expensive hospital care, to thinking about other places of care, especially in those cases when hospital care is likely to be ineffective in extending life, or detrimental in fact, to the quality of life of the patient and the patient's family.

Thank you.

[The prepared statement of Dr. Barbaccia follows:]

PREPARED STATEMENT OF JOSEPH C. BARBACCIA, M.D.

Increasing costs of medical care for the aged as well as for younger Americans is an issue that has warranted national attention for the past dozen years or so. While many suggestions have been made and many approaches taken with ways to limit or bring down costs of health care, only a few have had limited success. Because costs of hospital care are so high (in San Francisco, the price a day of hospital care ranges from about $900-1300 depending on the particular hospital), a number of mechanisms have been considered to bring down hospital use by substituting other levels of care when possible. For example, health maintenance organizations are known to avoid the use of hospital care whenever possible by substituting care in the outpatient setting. Voluntary control of price increases such as by physicians, has had limited success since it is often confined to one group or another, and doesn't always involve the greatest segment of cost which are hospital costs.

In late 1984, Medicare began its system of prospective payment to control hospital costs for Medicare beneficiaries, again with moderate success but very successful in setting off a large number of complaints from physicians, patients and hospitals all based on the concerns about various issues but many complaining about the same issues from different prospectives. Most complaints are related to fewer days of hospital care that someone felt were warranted. There have also been retroactive denials by payors of care for whole or part of a hospital stay.

When Medicare was enacted in 1965, the desired effect of government payment of medical care for the elderly was to increase access to all elderly regardless of their ability to pay since so few elderly had third party health care coverage. Medicare was to pay for all levels of care for any acute episode of illness—from hospital care to nursing home to outpatient care. It was anticipated that the medical care system, especially physicians, would order appropriate level care and unnecessary days of hospital care would be largely avoided as would unnecessary costs. This perspective required that nursing home and in-home care would be as readily available and as "in demand" as care in the hospital. Medical necessity of necessary care was to be determined by an "impartial" group of care professionals and the appropriateness of each unit of service was to be reviewed to avoid over utilization. Services would be paid for on a reasonable cost basis and the entire system would function in an "ideal", balanced and rational manner. Unfortunately, Medicare provided many financial incentives to use the acute hospital as a place of care over other settings and there were few incentives not to increase prices of services provided in hospital and by the hospital. Under these conditions, the price of a day of hospital care increased 15 to 18% each year, a rate considerably more rapid than other elements of the Consumer Price Index. Many factors contributed to hospital price increases including increasingly complex medical procedures and technology and use of a wider range of hospital services. Currently, ⅔ of the monies paid out for Medicare benefi-

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ciaries is for acute hospital care even though the length of stay of each hospital admission has been decreasing progressively. Increasingly rigid criteria applied to determining medical necessity of services, appropriate use of services and voluntary and then mandatory freezes of physician fees have not reduced increases of hospital care costs nor of the proportion of dollars paid for hospital care.

Because of the attractiveness to government of prepaying for health care since annual costs can thereby be anticipated and because of ample evidence that health care organizations which accept prepayment tend to use less acute hospital days per enrollee than other health care organizations, a prospective payment system (PPS) for hospital care for Medicare beneficiaries seemed the most promising way to limit hospital costs. Fiscal incentives for hospitals to limit the number of days of hospital care and hospital expenditures incurred during any one day of care were seen as the only way to finally control the amount of money paid by Medicare to hospitals. Under the PPS, the hospital receives a fixed rate of reimbursement for all patients with the same diagnosis, (e.g. myocardial infarction), after corrections are made for the age of the patient whether the patient had surgery or not, for the presence of complicating conditions or for the complexity of the patient's illness. Under this system, hospitals are obviously interested in receiving as much money as possible for any one patient in spending as little as possible in providing care and in having the patient stay as few days as possible. Regardless of how long the patient stays, the amount of money the hospital receives is on the basis of the patient's diagnosis not on the basis of how many days of care provided.

Monitoring medical necessity for Medicare patients' admission to hospital as well as appropriateness of continued stay in hospital is the responsibility of the hospital's utilization review team. The hospital and medical staff also have the responsibility of monitoring the quality of care provided by physicians as well as all other health care personnel. Hospitals and physicians are in turn monitored by Professional Review Organizations (PRO's) for appropriateness, medical necessity, amount of services, and quality of services provided to Medicare patients. Medicare fiscal intermediaries also monitor provision of services by specific hospitals and admitting physicians. The aim is to control costs of hospital care without compromising quality.

In the prospective payment system, as in any other system of care where it is the physician who orders medical services, the physician also orders admission of the patient to hospital as well as discharge from hospital when the patient no longer needs hospital care. In addition, it is the physician who orders in-home services for post hospital care or care in a skilled nursing facility (SNF), when appropriate. From the hospital's perspective, the most desirable patient the doctor can admit is one whose diagnosis is paid for most generously, consumes the "right" number of services during the hospital stay, stays for as few days as possible, and when ready to leave will do so as quickly as possible. Obviously, the patients of some specialists, e.g., of cardiovascular surgeons who require coronary bypass procedures are very welcome while those of other specialists are not, e.g., the chronic pulmonary patient who has no family, is in repeated acute pulmonary failure and unlikely to recover but requires a prolonged hospital stay.

Under the Medicare prospective payment system, with its increasingly stringent hospital admission and continued stay criteria, patients who do get into hospital are sicker when admitted and are likely to be more disabled and dependent when they leave hospital. When such patients arrive at the SNF, they need more nursing and medical care and when they arrive home after hospital, need more in-home service than was the case before PPS. Yet, the irony of this situation is that, because of the overall impetus to contain Medicare costs, even though in-home services and SNF services are ordered by physicians for these sicker patients, fiscal intermediaries are currently likely to authorize fewer services and are likely to retroactively deny payment of services provided by in-home service agencies especially. This is my experience in San Francisco since I have personally looked into the situation currently faced by the VNA of San Francisco, the largest in-home service agency in San Francisco.

There is no question in my mind that physician are pressured by hospitals utilization review teams to discharge patients when all that can be done for patients in acute hospital has been completed and before patients are as independent in self care as they might be if a more prolonged period of convalescence more possible.

As one would expect, those patients who cannot care for themselves who have an elderly or disabled or no spouse or family to care for them, and who need chronic medical care and intense levels of personal care but not acute hospital care, are the most difficult to move out of hospital. Obviously, these patients are the most difficult for the hospital's utilization team to deal with, most difficult for the attending physician and a huge burden on their family and informal support system if family

members are few. They can also be a significant burden on community agencies, especially if the patient and/or family find it difficult to pay out of pocket for in-home services or for long-term nursing home care.

Is it possible to quantify the enumerated problems resulting from the Prospective Payment System? At this point, it is impossible to count the number of patients who have died because of too early discharge from hospital or from the lack of proper in-home care or SNF care. My own opinion is that few serious problems have occurred as a result of these pressures and situations. Yet the possibility of future legal problems is always present in our litigious society.

There are a number of suggestions that I would like to make that could contain some of the impact of early hospital discharge as well as serve to monitor for any complications that might result from premature discharge from hospital. Foremost, we must all understand—Medicare beneficiaries, family, physicians, other health care workers, politicians, body politic: Medicare is a payment mechanism for acute medical and rehabilitative care; it is not intended to meet social needs or long-term care needs. The United States is in desperate need for a long-term care plan for the middle class—the non-destitute and the non-wealthy. Secondly, Medicare has been too oriented to hospital care and must now provide financial incentives for outpatient and in-home care while carefully examining better ways than by repeated hospitalization of providing intense levels of care required in the last six months to one year of life of severely and hopelessly ill patients.

In respect to efficient use of acute hospital care, more careful discharge planning must be done by discharge planners in cooperation and collaboration with physicians, family and community agencies. Discharge planning must begin as soon as the patient is admitted to hospital or before, if possible. Some physicians can no longer remain aloof of the discharge planning process by delegating it totally to others or by remaining uncooperative. Discharge planning must be considered the business of the hospital and the physician and not taken as an interference in the doctor-patient relationship.

The patient care review and quality review committees of the medical staff and hospital must monitor too short hospital stays and instances of rapid readmission, i.e. within 24 hours to 15 days after discharge so that problems brought about by too early discharge can be dealt with at the hospital level, whether they are a result of a physician's order, pressure from the UR team, inadequate discharge planning, inadequate or inappropriate in-home services, or social reasons. The PRO must also carefully review hospital performance when these same situations are noted or when unanticipated complications or deaths occur.

Additionally, it is well recognized that payment to hospital for a number of DRG (Diagnostic Related Groupings) categories is inadequate. Some patients who are severely ill and require complicated care are not paid for adequately by Medicare. The PPS Commission which periodically adjusts payment, must look into these cases as soon as possible.

Finally, hospitals should consider the establishment of "step-down" beds for patients who need the hospital environment for adequate early convalescence that could not be conveniently provided elsewhere. The cost of such care should be less than in the usual hospital bed and affordable, if it would avoid the penalties of rapid rehospitalization in carefully selected cases.

As the number of "very old" (85 years of age and over) increase in the American population, the health care system and policy makers need to rethink ways to charge from our over dependence on expensive hospital care in cases where it is likely to be ineffective in extending life or detrimental to quality of life of patients and difficult on their families.

Senator WILSON. Thank you very much, Dr. Barbaccia.

Dr. Robert Reid is a physician in a community practice in San Jose which serves a number of elderly patients. He is the immediate past president of the California Society of Internal Medicine; board member of the Hospice of the Valley and a member of the California Medical Association's Peer Review Organization Monitoring Committee which monitors the activity of the California Medical Review, Inc., which is in California, the PRO.

We are delighted to have Dr. Reid with us.

Welcome, sir.

STATEMENT OF DR. ROBERT REID, COMMUNITY PRACTITIONER, SAN JOSE, CA

Dr. REID. Thank you, Senator, for this opportunity to address this, what I consider, very important problem.

Many of my points have been made and I will try to not reiterate all of them. Dr. Barbaccia very well summarized the problems. I think one of the problems is I fail to hear enough discussion of the fact that these so-called beneficiaries which I prefer to call patients, are different than those under 65. No one is stressing the fact enough that these patients have less support at home, less support through their families, less support as mentioned, no spouse around, they have less support from insurance companies and yet they have the greater share of medical problems. They do indeed encompass and utilize a greater share of the financial health care dollar, but they do indeed need this.

They do indeed have longer length of stay, and Dr. Moncrief very adequately addressed the fact that the PRO's are not interested in length of stay, not until they become an outlier and have been in more than 21 days plus, et cetera, for example. However, the hospitals are, the patients are, the families, are, and the physician, who has been laid upon this heavy burden of deciding, as mentioned before, when the patient is hospitalized, during the hospitalization and when the patient is to be discharged. The hospital is no longer allowed to admit Medicare patients for terminal care. We have heard this. It is an inhumane, incompassionate way that we treat these patients. It is very difficult when you have to explain to the family that this admission for terminal care may not be covered. One may have to allude to such things as intravenous fluids and pain control with injections in order to not lay upon the burden of this terminal care on the family and the estate of the patient.

Yes, there are increased pressures for the doctors to discharge their Medicare patients, but this is not new in my practice, having been involved with the formation of an HMOIPA, which does indeed save dollars by reducing the length of stay.

The problem is you cannot apply these data, these guidelines from the younger under 65 age group to the over 65. As I mentioned, these are different patients. These are older patients. Hopefully all of us will eventually reach that point where we can appreciate these differences.

We have heard about the transfers to skilled nursing facilities. Yes, this should be done. Unfortunately, Medicare has such strict guidelines as to reimbursement, they pay very little of the SNF charges, this is laid on to the State or the families or if these people are fortunate enough to have skilled nursing facility insurance coverage, then they get some benefits there, or they may have to pay out of pocket.

The current major problem I see in my county is patients with tracheostomies. The recommendations are that these can be cared for at a skilled nursing facility. This, however, is not the realistic case. They do not have the trained personnel to care for these and I can vouch for the transfer of a patient with a tracheostomy with amyotrophic lateral sclerosis requiring readmission at a subsequent date because there was not adequate care for his tracheostomy.

One of the things not alluded to is the extreme pressure that I feel only because my patients require uncomplicated surgery. The PRO's are requesting that hernioplasty be done as an outpatient; that the patients be done and sent immediately home. In one week there were three patients, average age 75, all requested to go home immediately after surgery. This can have a profound effect on the recovery of the patient and also a subsequent event on the liability which these surgeons must face under this undue pressure.

Home health agencies. There are increasing pressures for visits, increasing pressures for physical therapy visits, occupational therapy, and speech therapy, because we are indeed sending patients home where they can be adequately cared for. We are attempting to give as much support to the loving spouse who attempts to take care of these patients.

The hospice reimbursement plan was thought to help alleviate the expense of hospice care. It has not. Only approximately 50 percent of the hospices participate in Medicare reimbursement for their services.

I think an important point is that the Senate, Congress, must follow through with the planned studies which I have recently read about. They must study and clarify the magnitude and the frequency of adverse effects of the PPS, DRG system on the quality of care. Quality of care is like beauty, it is in the eyes of the beholder.

I have heard this morning about the PRO's instead of delegating quality review as they were originally advised to, or given the option to, that they are going to develop a new program to study quality of care in SNF's, in the hospitals, et cetera. I see no reason to reinvent the wheel. While they were talking about four cases of physicians being brought to bare for poor quality care, we denied the reappointment of three physicians to our hospital staff because of deficient quality of care. The mechanism is there for PRO's to work with the hospitals. It certainly would be financially expedient to do this, and physicians are definitely interested in quality of care.

One last comment on capitation so I don't forget. It has been alluded here that capitation may be the answer to the Medicare financial problem. I beg you to study all ramifications of capitation because many forms of capitation reduce access and underutilize. Thus we should not go into this blindly without studying it completely.

Thank you.

[The prepared statement of Dr. Reid follows:]

PREPARED STATEMENT OF DR. ROBERT H. REID

INTRODUCTION

Senator Wilson, I want to thank you for having the opportunity to address you regarding my experience with the Medicare Prospective Pricing System (PPS). I have been in practice in internal medicine over the past 21 years. I have a subspeciality of oncology. 30% of my practice deals with patients over the age of 65 and thus covered by Medicare. I am also a medical director of a skilled nursing facility that has experienced care of the aged in that regard.

I would certainly feel that the guidelines which have been set up by Medicare regarding Utilization Review and indicated appropriate admissions are quite rigid. The over-age-65 group does utilize a larger share of Medicare medical dollars because they have a larger share of medical problems. The guidelines as to utilization

and length of stay should be different for Medicare patients than the under-65-years group. This is frequently necessary because of the reduced support which Medicare patients have from society and their family.

I would like to now present examples which I have encountered since the institution of the PPS-DRG system.

1. Frequently admission of Medicare patients is questioned because of their terminal status. Medicare continues to deny admissions for terminal care alone. In cancer patients where hospice services are available, these patients may be covered through the hospice reimbursement plan. However, many of the diseases of the elderly are not covered under the hospice plan. It is incompassionate to deny terminal care for Medicare patients when hospitalization is indicated. Not all patients can die at home.

2. The length of stay for Medicare patients may well be longer than for younger patients. The data indicating length of stay guidelines for different diagnoses apply more commonly to otherwise healthy patients with a single medical problem. Medicare patients, as mentioned previously, have more than one diagnosis and often as many as six to eight different diagnoses, all having an effect upon the recovery from the acute illness. Thus, pressure to discharge patients from hospital Utilization Review Committees needs to be tempered by complete and thorough knowledge of all diagnoses and also of social factors.

In hospitals throughout California, for many years, there have been pressures to discharge patients at an appropriate time. This has now been transferred to the Medicare patients but again must be tempered by dealing with a different age group. Insurance companies and HMO's have been dealing with a younger age group which again have greater support from family at home.

3. Increasing pressure to discharge patients after acute hospitalization has resulted in increasing need for home health services. There has also been an increasing need for skilled nursing facility or convalescent home admissions. This increased load has led to greater demands on most home health care and SNF's. The severity of illness of these patients admitted to the home health services and SNF's is quite apparent. The care of tracheostomy patients cannot be carried out in the majority of SNF's. Only those dealing with hospice care have the 24-hour skilled nursing personnel to handle these extremely sick patients. We are seeing, however, increasing pressures to transfer these severely ill patients from the acute hospitals to SNF's. This undoubtedly results in a poor quality of care for these patients. Again, cost should not be the sole determinant as to continual hospitalization, but compassionate and humanitary reasons should be considered.

4. Under the Peer Review Organization process, both Utilization Review and Length of Stay Guidelines have been set up. These guidelines are rigid and focus on certain specific diagnoses. They do not consider the many other medical problems these patients have and also do not concern themselves with social factors. A given example of a question of the appropriateness of admission of a 75 year old female with pneumonia. The physician advisor calls me two months after the fact, questioning why this lady was admitted with pneumonia. I asked the physican reviewer to read the subsequent diagnoses: #2 was gastrointestinal bleeding, #3 was hypertension, #4 was history of hypertension. Thus, there were other contributing factors to the admission, however, the primary reason was pneumonia. Also, this 75 year old patient lived with her son, who worked 50 hours a week and was not available to see the patient getting the proper care. This latter social problem was only one of the many factors which dictated that this patient be admitted. Thus, the PRO's must take into consideration all aspects of these patients' care requirements.

5. A most recent planned discharge of a patient at my hospital was a 70 year old patient who was terminal from a brain tumor. The pressure was to discharge this patient home to the care of the family and yet the prognosis of 48 to 72 hours of survival time. I again plea for compassionate decisions as to what is best for this patient.

In summary, I have attempted to focus on what I have encountered as to the problems with the Prospective Pricing System—DRG. As the pressures to contain costs continue, and as our over-65 age group increases, I can see only an increase in the frequency of these problems we have encountered to this date. I would feel that the rigid guidelines having been set up for utilization review and quality of care must be tempered with the compassionate, humanitarian aspect of the practice of medicine.

I thank you.

Senator WILSON. Thank you very much, Dr. Reid.

Ms. Patricia Worthen is a discharge planner and a director of social services for the hospital of the Good Samaritan in Los Angeles.

She has also been the director of clinical social work, Valley Hospital Medical Center, Van Nuys, and a social worker at Northridge Hospital in the Head Trauma Rehabilitation Program, and we are delighted to have you with us.

STATEMENT OF PATRICIA WORTHEN, DISCHARGE PLANNER, GOOD SAMARITAN HOSPITAL, LOS ANGELES, CA

Ms. WORTHEN. Senator Wilson, thank you. I appreciate the opportunity to be here this morning and to be able to share with you some of the impressions and the experience that our social service department had during the first year that we were on PPS. For our hospital, which is the hospital of the Good Samaritan in Los Angeles, our fiscal year, the first time that we were on PPS, was from September 1984 until September 1985. So we have just really completed that first year.

The hospital has through total admissions, about 60 percent of the patients in our hospital at any one time, would be considered on Medicare. Most of those are age 65 or over as opposed to ones that might be disabled. But we have had as high a proportion as two-thirds, upward toward 70 percent. So we do a great deal of work in our social services department with discharge planning with elders and other types of counseling and social work services, linkages to services in the community when people are leaving the hospital.

I would guess that at any one time probably our departmental case load runs around 80 percent, age 65 and over.

During this year, fiscal year 1984-85, I think we noticed two very drastic changes in our department, one was related to the subject we have been discussing a great deal this morning, and that is the skilled nursing home industry. We saw a 35-percent increase in the numbers of patients that we placed in skilled nursing facilities during that year. We place approximately 50-60 individuals monthly at this point in time in nursing facilities.

Concomitant to that, we saw a tremendous rise in the number of what you would call a "subacute" bed need in the nursing facility. This would be for the patient who is no longer at the acute care level, but still has some need for hyperalimentation, has IV lines drawn for nutrition or hydration or even pain control reasons. Also it could be for patients that would need some type of suctioning because they might be on respirators or ventilators.

These beds in our area, anyway, tend to be very rare, extremely rare, so we were certainly faced with a tremendous impact on the patients, their families and our hospital and community related to trying to find beds that really weren't existing or weren't available. Although some nursing homes, in my experience, did create small units, 10-bed units or even larger than that, 15-25-bed units for subacute care on a special certification with Medicare. It still didn't totally meet the needs that at least we were experiencing in our hospital.

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The second major change and impact that we have seen is related to case or patient management. We found that with the shorter length of stay in the hospital, it became imperative that we identify the high risk or at risk patient very early in the game; at admission or even preadmission in circumstances where family or physician would notify us early that the patient was coming into the hospital, and there were very definite types of social problems involved with that admission.

Discharge planning for us, I would say, in the last 18 months has really become an extension out of the hospital into the community where we find ourselves spending a great deal of time doing what we are really referring to as case management. This is looking at the functional level of the patient, what they are able to do when they go home, and trying to link in as many services as we can. Monitoring of those services also is extremely necessary and with the very ill and the very elderly patients, we are thinking monitoring on a life span basis, is actually what is needed.

Periodic studies in our department reveal that, when we have done a monthly study, we have found about a third of our caseload is in need of this type of case management; the linkage concept and the monitoring concept service. This for us would represent on a yearly basis, just about 1,000 patients if we were to generalize our studies to our annual caseload.

We have found that by approaching discharge planning as something that does not start half way in the stay and end at the time the patient leaves the hospital, we are trying to look at it and plan and write proposals to fund a case management system that would be involved with the patient throughout whatever their lifespan might be. We are actually looking at two objectives here. One is to support, to underpin the medical treatment and recommendations that have been made, and the other is to avoid the premature institutionalization and by that I mean primarily into the nursing facility which in most cases is thought to be much more costly.

Thank you.

[The prepared statement of Ms. Worthen follows:]

PREPARED STATEMENT OF PATRICIA WORTHEN

We face an extraordinary problem in the United States. The cost of health care continues to rise, and yet our health care system systematically fails to meet the needs of an alarming number of Americans. This paradox has been noted for at least the past 20 years, but now there is an additional complication of the pressures created by the concensus that an upper limit is being reached on the proportion of the national product that should be spent on medical care. The health care dilemma of the 80's has become how to mesh the American ideology of health care for all regardless of socioeconomic class or status with the need to limit the rising expenditures for such care. In other words, how to move toward equality and toward cost containment at the same time? This will be an extremely complex task, both morally and practically, as our population ages and as more Americans live to an age when medical care becomes both more necessary and more expensive.

We are all familiar with the numbers. By the year 2000, one in five Americans will be 65 & over while those in the age group of 85 and over will double. Even at present, 11 percent of the population, namely those 65 and over, account for 25 percent of hospital discharges, 28 percent of all prescriptions and approximately 30 percent of all health care expenditures. PPS is a direct result of the federal government's attempt to meet the demand for current health care needs of Medicare recipients. The question, then, becomes how, in the future, can Medicare meet the increasing medical costs? More importantly, how can these costs be met in such a way

as to asure quality of care for our elder population? Quality is a very definite issue in the thrust for cost containment and cost cutting.

Given the public policy commitment for reduction of the federal budget deficit, there would seem to be little doubt that PPS or other programs focused on cost containment (e.g., vouchers, capitation) will continue to have a tremendous impact on the health care industry, the health care consumer and the social welfare system.

More specifically, the effects of PPS and issues of quality care can be examined at the micro level of a Social Service Department in a non-profit, community hospital where 60 percent of the admissions during fiscal year 1984-85 were Medicare patients. During this first year that the Hospital of the Good Samaritan, Los Angeles, was operating under the PPS (i.e., September, 1984—September, 1985), the Department noted a 35 percent increase in patients placed in skilled nursing facilities. At the same time, the Department initiated high risk screening for discharge planning and found that as a result of the "quicker, but sicker" syndrome, one-third of the patients returning to their home situations were in need of follow-up, case/patient management services. This one-third of the Department caseload represents approximately 1,000 patients who, with few exceptions, were age 65 and over.

From the viewpoint of a Social Service Department carrying the responsibility for discharge planning, there has been a number of quality care concerns and issues which have surfaced as a result of the experience with PPS:

(a) The fact of patients leaving hospitals while still in need of intensive nursing care has created a concomitant need for sub-acute beds in skilled nursing facilities. Although some sub-acute units have been developed, the nursing home industry has not been able to upgrade its services quickly enough to meet the increasing needs.

(b) Recent changes in the way Medicare reimburses for Home Health Services has had, in effect, a reduction in the type and amount of service available to patients in their own homes.

(c) The tendency toward creation of a dual system of health care (one for the poor and another for the middle-classes) with cost shifting of government insured patients to the public sector for medical treatment.

(d) A lack of individuation, i.e., the possibility of patients becoming a DRG number without regard for individual dignity or self-determination.

(e) Heightened feelings of anxiety, anger, confusion on the part of patients and family members as they try to understand and deal with the complexities of Medicare, now compounded by PPS.

(f) The growing need to mesh home health services into a long term care (LTC) system which would include case management, adult day care, homemaker services and geriatric evaluation centers (with mobile units). The purpose of these programs would be to avoid premature institutionalization of the elderly which in most cases, is more costly than in-home services.

Senator WILSON. Thank you very much, Ms. Worthen.

Ms. Sharon Grigsby is the President of the Visiting Nurse Association of Los Angeles, a nonprofit organization delivering home health care to many elderly patients.

Ms. Grigsby, I saw you most recently last night watching the video tape of that program of "Growing Old in America."

We are delighted to have you with us and have your particular perspective as it relates to the delivery of home health care. Welcome.

STATEMENT OF SHARON GRIGSBY, PRESIDENT, VISITING NURSE ASSOCIATION, LOS ANGELES, CA

Ms. GRIGSBY. Thank you, Senator, and I do appreciate the opportunity to come and speak with you and the group on the subject of the impact of the Prospective Payment System on the home health care industry.

The Visiting Nurse Association of Los Angeles actually is perhaps somewhat atypical of home health agencies in that we are organized as a voluntary nonprofit. The vast majority of licensed home health agencies in the country, and there are almost 6,000 of those now, are either proprietary or hospital based.

However, I do think that the Visiting Nurse Association experience with Medicare patients is very typical and valid, and I am quite comfortable representing this experience in the industry.

The Visiting Nurse Association of Los Angeles sees almost 9,000 Medicare recipients every year, and this year is expected to provide some 165,000 visits. I feel we do have quite a depth of experience in providing this kind of care to Medicare population.

One of the other points that I think I would like you to know in terms of understanding the testimony, is that the Visiting Nurse Association of Los Angeles has one of the lowest visits per case ratio in the State. We must file State reports every year to demonstrate what our visits per case experience is. I say that not to brag, but simply to say that we traditionally have a very lean approach to the utilization of Medicare services. We try to make sure that the patient has what is needed, but we are very, very careful that we don't overstate those needs, we are very conscious of the need to control the cost.

Similarly, I would also point out that we have a very good report card as it were from the fiscal intermediary on our quality service. We were subject to a recent audit and on a random sample of 400 Medicare visits that they pulled, we had no medical denials. I say that again to demonstrate that we work hard to walk a tight rope between quality of service that is necessary to maintain, and a minimalization of the cost of the visits that we use to provide that service.

Against that background of establishing for you the experience that the VNA has, I would like to discuss four areas where we have felt strong impacts from the PPS program in the hospital.

It seems very clear from the testimony you have heard that all health care is a continuum. You heard that two-thirds of Medicare expenditures are for hospitals. Anything that affects that big a part of the system obviously is going to have major ripple effects on the rest of the system. In our agency we have seen a 15-percent increase in Medicare patients each year since the implementation of DRG's. The significant thing to me is that those 15 percent of the patients have used 30 percent more additional services so that they are coming to us in need of more services. Again, I would remind you that we traditionally run very lean so we are not inflating these numbers. It is just that as these patients have come out of the hospital, they have needed more visits per case than they did 2 years ago. So volume impacts are a major and visible sign that we have seen since the implementation of DRG's.

The other major impact since DRG's has been on programs. These patients as you have heard some of the physicians describe, are now being discharged with technical support needs that they never left the hospital with before. They are going out with IV's, they are going out on TPN, they are going out on ventilators and we have had to have the programs in place to care for those patients. Certainly that was not a level of care that was provided in the community before, and it is one that increasingly is capable of being provided safely and effectively in the home if the proper support is there. That support obviously is professional care as well as teaching. Our goal is always the independence of the patient and the family unit. So teaching the family and the patient as much

self-care as possible takes a great deal of time, and has an impact on our program. We find ourselves having to hire a lot more specialists that can deal with patients that have these more involved situations. Our intravenous team has had substantial increases. In the last year we have had 44 percent more visits from the intravenous team. We have had to train our nurses to handle the routine intravenous support so that the intravenous team can only take the specialized cases or new admissions, or the most complicated cases. Formerly, the team handled anyone that came in on an IV.

Similarly, our hospice services are way up. We have had almost a 50-percent increase in our hospice services in the last 2 years, and while that is a growing trend nationwide I think it ties to some of the comments you heard earlier about how we can provide a humane environment for the terminally ill. However, it does put a demand on experienced specialized staff in the home health industry.

Throughout, we have the programmatic implications of how we keep quality assurance high in the face of these kind of volume increases. Our quality assurance systems have to monitor constantly the greater number of patients who are coming in the door sicker and requiring more specialized services to see that they are getting what they need and that the quality is being maintained.

The third area of impact has been on staffing, and obviously we have needed to hire more staff to meet this kind of load. We needed to hire staff with higher technical skills. It was not formerly, a requirement that incoming nurses have their IV certification, for instance, but now that is a requirement. We essentially don't hire a nurse coming on without IV skills or she has to acquire them shortly after coming because that is going to be necessary in caring for the patients she sees.

The nurse we want, increasingly, is the same nurse that the hospital ICU's are pursuing and we find ourselves then having to compete with hospital intensive care units for very specialized or experienced staff.

We need a lot more in-service training. Our field staff has to constantly have their skills upgraded and updated to meet the needs of these increasingly more demanding patients.

Now, we have also had to go to extended hour and 7-day-a-week coverage that was rarely seen in home health three, 4 or 5 years ago where it tended to be a Monday through Friday, 8 to 4:30 kind of business. Now we simply don't have that luxury. We have patients sometimes that we see twice a day when they first come out of the hospital, and so we have to have extended hours. Also, we have to have coverage on the weekends when the hospitals needs to move a patient out on a Friday, Saturday, or Sunday. We have to be available to take that patient; they simply can't wait until Monday to be seen.

The final area of impact has been financial. That has come about because we have seen these increasing pressures on cost because we have to do more technical interventions, and we are spending more time in the home. We have seen our nursing costs go up over 10 percent on the last cost report that we filed due primarily to increases in time in the home. Our productivity is falling because we simply cannot walk out of that patient's home in 30 or 45 minutes

which was more typical before. We are increasingly in the home in 1 hour or 1 hour and 15 minutes and that is driving nursing costs up. So, we are having to pay higher salaries to compete for these more technically skilled personnel; that is pushing costs up.

The expanded hours where we pay shift differential and overtime, push up costs. We are required to do more sophisticated budgeting and reporting, and I am sure you have heard a great deal about recent changes in home health record keeping that are all costing us more.

At the same time we are finding reimbursement coming down. I think Dr. Barbaccia made the point a little earlier about the apparent irony that his patients are coming out of the hospital in need of more home care support in order to remain at home safely and not be readmitted. The fiscal intermediary is taking at least as hard a line, and in many cases a harder line on home care costs, but somehow the very fact that these costs are growing is disturbing to HCFA. Instead of seeing it as a related after-effect of inpatient savings, and really a much cheaper way of maintaining those savings, these cost increases are looked at as a problem in itself. We have had to deal with a recent HCFA move to reduce the cost caps in Medicare. We have been functioning under caps for the last several years. Now we will face decreases in cost caps this year and in the next 2 years. We have had a change in the costing methodology that will also reduce our reimbursement because we will not be able to offset high cost disciplines, physical therapy or speech therapy or social work, with the high volume costs in nursing. Now each of those has to be costed separately and that will cost most home health agencies cuts in their reimbursement.

Also we have a constant problem of adverse selection. In the voluntary nonprofit sector, we tend to see the patients that either are the most complex, or that have exhausted their benefits or that have no kind of health care coverage. So we tend to wind up with the most costly patients to care for. We have a great deal in common with the public hospital sector in that we become the provider of last resort for a lot of these patients. That of course drives our costs up.

My concern would be that for the hospitals to continue to succeed in their decreases in Medicare utilization, they must have safe alternatives and supplements to the care provided in the hospital. Without the continuity of care that discharge planning is working to achieve, without adequate funding for after care resources, we will lose the advantages, financial and programmatic, that were the goal of the PPS system in the first place.

Thank you, Senator.

[The prepared statement of Ms. Grigsby follows:]

PREPARED STATEMENT OF SHARON GRIGSBY

My name is Sharon Grigsby and I am President of the Visiting Nurse Association of Los Angeles. I appreciate this opportunity to offer testimony on impacts I have observed on home health services due to the change in Medicare reimbursement to hospitals. While Home Health Agencies have not been placed on prospective reimbursement, these agencies have been the recipients of major impacts as a result of DRG implementation.

As a direct result of Medicare reimbursement changes the Visiting Nurse Association of Los Angeles has been subject to impacts in four areas: volume impacts, pro-

grammatic impacts, staffing impacts, and financial impacts. This testimony will be addressed to those four areas and to some unmet needs and recommendations in the home health area.

By way of background the Visiting Nurse Association is well qualified to address these issues as it is the largest home health agency in the Western States and has been providing home health care since its incorporation in 1939. We may be atypical of the more than 5,000 home health agencies nationally in that we are a voluntary non-profit organization. I believe, however, that while non-profits are few in number in our industry this characteristic might offer additional credibility to today's testimony in that our mission is not to provide a profit, but only to provide care to all who need it without regard to ability to pay. It is also important background for understanding the arguments and statistics to be presented today to know that the Visiting Nurse Association of Los Angeles, while providing some 165,000 visits to over 9,000 Medicare beneficiaries this year, has consistently reported one of the lowest average visit per case figures in the state. Also, in a recent detailed on-site review of 400 randomly selected Medicare visits, our agency has received no denials of payment due to lack of medical necessity. This means that we have demonstrated a very lean approach to Medicare patients needing home care services, erring if anything on the side of underutilization, while documenting a level of quality with which the fiscal intermediary was unable to find fault.

These statements are not made with intent to boast, but rather to establish a basis for the validity and the patient care orientation of the experience behind the remarks being made today.

IMPORTANCE OF THIS ISSUE

It is widely known that the elderly are the fastest growing population group in our country. California has a disproportionate number of the aging with the highest percentage of residents over 65 of any state. And our elderly have a higher life expectancy than for the nation as a whole. (CHA Study: Strategic Planning Assumptions for Hospitals, 1985.) While the aged made up 11 percent of California's population, they consume 30 percent of the health care dollar. Of the taxpayers' dollar for publicly funded health care, the elderly consume a full 50 percent. And more than one Medicare dollar in five is spent in the patients' last year of life. One in five of the elderly is hospitalized during the year, remaining in hospitals four days longer and spending three times more per capita for health care than persons under 65.

These statistics make self evident the concern for the future of the Medicare program and its ability to meet and fund the growing needs of the population it was designed to serve. As the CHA study points out, "The area of greatest long term growth in the health care industry will be in developing creative approaches to the health care of the aging population."

One approach thought to be creative, was the implementation of Diagnosis Related Groups as the Medicare hospital reimbursement basis beginning in 1983. By mid 1984 most California hospitals were on DRG's. You are hearing about the effects of this shift from Medicare beneficiaries and from hospitals and physicians. It is the purpose of my testimony today to describe the results of this shift on home health agencies. In order to understand why a change in payment mechanism in the hospital sector should have such significant ramifications for another industry, it is important to emphasize a central fact all too often conveniently overlooked by those financing health care: all health care is on a continuum mapped out by the patients' need for service. From physicians offices, outpatient clinics, inpatient services (primary, secondary, and tertiary) skilled nursing facilities to hospice and home health, all these systems for providing care are linked by the needs of the patient flowing though them. Just as what services (content, duration, quality) a patient receives in each part of the continuum are heavily affected by the financing of those services, so too is the location of those services influenced by the financing. Clearly, if inpatient care will not be reimbursed after so many days or for certain surgical procedures, that patient's care will not likely take place in the hospital.

Even with some potential for overutilization alleged to be inherent in fee for service reimbursement, there still is little argument that very large numbers of very ill and impaired Medicare beneficiaries have been cared for in inpatient facilities. California, with one of the lowest average lengths of stay (ALOS) in the country, experienced decreases in ALOS from 6% to 9% in the first year of DRG implementation. The hospitals also experienced rising acuity and severity levels as the not so seriously ill were not admitted at all, but received outpatient surgery or home care; or admitted for much shorter stays. This lopping off at both ends of the bell curve of hospital patient acuity had significant impacts on hospitals; which I am sure you have

been hearing. However, I would like to discuss the impacts of tightening and heightening this curve on the home health industry.

Like the python digesting the elephant, the large lump in the middle must move through the system. The elephantine lump of more elderly persons, living longer, accruing more interrelated chronic conditions, requiring more care and being served under a constricting system for inpatient services is being disgorged to nursing homes and home health agencies. You are hearing today of how ill-prepared the nursing home industry is to serve these seriously involved, heavy-care patients. Home health agencies face many of the same dilemmas.

VOLUME IMPACTS

Since DRG implementation, our agency has experienced a 15% annual increase in Medicare patients served. This may not seem so remarkable unless one considers that the aging population is not increasing at anywhere near that rate, neither is the number of new Medicare enrollees. The most telling figure, however, is that these 15 percent more Medicare patients consumed 30 percent more nursing visits, evidencing the increased acuity or high level of need for care presented by these patients. Additional testimony to the acuity of these patients is the fact that while professional nursing visits grew by 30 percent, nonprofessional Home Health Aide visits increased by only 7.3 percent: the patients clearly needed more, and more frequent, professional nursing intervention.

In addition to increases in numbers of patients and numbers of visits, these Medicare patients are staying longer on service, by almost a factor of two, than our under 65 patients (32.8 days vs. 16.9 days) and using more specialty care services. For instance, the intravenous team (serving patients coming home on IV's for antibiotics, chemotherapy, TPN or vein feedings) has seen a 44 percent increase over the course of this year and the hospice service for terminally ill patients has increased by over 50 percent in the last two years. Individual visits are taking longer as a result. The patients require more, and more highly technical, nursing interventions during the visit.

The combination of more visit volume from more patients, more acutely ill, requiring more time per visit is the most visible impact of DRG's on home health.

PROGRAM IMPACTS

The sharply rising volume and the high level of care needed by these patients are having significant impacts on home care programs. We have had to add program specialist capacity (I.V., Enterostomal Therapy, Hospice), allow more time for administering these specialized services and for contact with the physician, pharmacy company or equipment maintenance firm. Also a big challenge is making available the time necessary for teaching families and patients who are often poorly prepared to deal with the complexities of equipment, tubes, dressings, and supplies, how to meet the patient's care needs between visits of the nurse. Overall, our key concern is now to assure continued quality of the program when faced with higher volumes of sicker patients.

STAFFING IMPACTS

Clearly we have had to hire more staff to serve these patients. We must require even higher skill levels from these nurses as they must deal with techniques, services, and equipment which formerly never left the hospital. We find ourselves competing with hospital ICU's for the kind of highly technically trained nurse we need. We are having to provide more in-service training for staff. For example, the Intravenous Team once handled all patients in all 6 area offices requiring any kind of I.V. support. Now the load is so great that the Team handles only new admissions and the most complicated cases. Staff nurses must now be I.V. certified and able to perform the routine I.V. work formerly done by the Team. Also, because of the acuity of patients, we must now staff for evenings, nights, and weekends. Formerly home health agencies were typically 8–5, Monday through Friday organizations. Their patients weren't sick enough to require anything more. Now 7 day per week operations with extended hours are essential to meet patients' care needs.

FINANCIAL IMPACTS

These expanded demands for number, type, and length of service have run up costs of care. Nursing costs are 10 percent per visit higher this year. The longer time per visit is the culprit. Where once nurses were budgeted for 7 patients per day, now they cannot make 5 visits. We control very carefully for efficiencies and

we are convinced this lower productivity is clearly the result of greater requirements for care. Our quality assurance mechanisms tell us that attempts to raise productivity by shortening visits would be deleterious to patient care.

Similarly, the need for more experienced, more specialized nurses means those advanced technical skills must be recognized in higher salaries. Since salaries and wage related costs are over 85 percent of our budget, this fact drives up our costs. Expanded hours require payment of overtime or shift differentials to attract needed staff; this runs up costs. And as we are finding out in other environments, periods of rapid growth put stresses and new requirements on infrastructure: the data processing and medical records systems: and the analysts, accountants, computer people to run them which also drive up overhead costs.

All of these pressures toward increasing cost, directly related not to inefficiency or waste but to patient care needs, are being countered by decreases in the reimbursement for home health care. Medicare cost reimbursement has been capped for several years. Our agency's costs have been consistently under these national caps. However, the cost increases we are experiencing jeopardize our position. Worsening the situation is the HCFA regulation change last July reducing the cost caps substantially over the current and next two years. A reimbursement change (DRG'S) which has created these cost increase pressures just described, is being compounded by other reimbursement changes limiting our ability to respond to service needs. A complicating factor is the additional HCFA change requiring home health agencies to cost each discipline's services separately. In the past all were aggregated. Since the vast majority of visits are nursing, some of the higher cost disciplines (social work, speech therapy) could be offset by high volume efficiences in nursing. Now this is no longer true and may result in some home health agencies being unable to afford to provide the services of these other disciplines. This would have the effect of denying Medicare beneficiaries access to needed specialty services.

Other complicating factors for those of us free standing non-profit agencies are the financial incentives provided by current regulation to for-profit and hospital-based home health agencies. These disincentives to freestanding non-profits threatened our ability to maintain our commitment to serve the indigent whose demands for care are rising also.

Voluntary non-profits also often suffer from adverse selection: medically and financially high risk patients are referred to us. It is not uncommon for us to get calls from for-profit competitors offering us a referral. Invariably the patient is an incredibly complicated case, or destitute, or both.

A final financial problem in the provision of Home Health services to Medicare beneficiaries needing them is the rapid growth of Medicare HMO programs. One estimate indicates that in our area 40 percent of the Medicare population is enrolled in HMO's. A significant problem for home health agencies is that often HMO enrollees are not aware of coverage limitations imposed by their HMO. They give us their Medicare number, we provide service and then get our bill rejected because the patients is in an HMO. The problem has cost us thousands of dollars in the last year.

With inevitably and unavoidably rising costs, and compressing reimbursement for care, home health agencies are being painfully squeezed. Without some recognition and relief of this problem, the up stream "solution" in the form of savings from DRG's, will be threatened. The success of DRG's in effecting reductions of Medicare costs to hospitals is dependent on a strong and effective pre and after care system.

Unless adequate systems of care exist to keep patients out of hospitals, it will have all been for naught. The hospitals can only succeed at reducing their Medicare utilization when safe alternatives and suppiements to hospitalization exist. Cost efficiency and patient care are both well served when home health agencies are allowed to provide high quality, adequately financed services to Medicare beneficiaries in their homes.

UNMET NEED AND RECOMMENDATIONS

We all, as taxpayers and program providers, wish to see improvements in the financing and management of government supported health care costs for the elderly. You will find a great deal of support for and commitment to program changes enhancing efficiency and saving cost. Yet none of us can lose sight of the fact that our national values demand safe and sufficient systems of care for our elderly. While we must plan for cost savings we should not overlook some present unmet need in the services to the Medicare population which can only increase cost when they are neglected. Two of the most glaring I believe are lacks of professional nutritionist and pharmacist support of home care patients. A recent study in conjunction with the University of Southern California School of Pharmacy documented major problems

when elderly patients, often on multiple prescriptions, become confused and make mistakes in taking their medications. Over half the elderly patients studied either under- or over-medicated themselves or had adverse drug reactions from medications which should not have been taken together. Services of a professional pharmacist could make an important difference in promoting the proper use of medications by the elderly and in preventing illness and even hospitalization due to misunderstandings and misuse of prescription medications. Currently, such professional pharmacist services are not reimbursed by Medicare and therefore, are not available to our homebound patients.

Similarly, the increasingly sicker patient we are seeing suffers from a seriously impaired nutritional status. Hospitalization, illness, strong, medications, all add stress to the individuals system which must be met by strongly adequate diets or the patient's condition must worsen. Yet, the patient is homebound, often with a poor appetite and a caregiver only slightly less frail than the patient. Our nurses spend a lot of time making referrals to Meals on Wheels and other community resources. However, there is no safe substitute for case by case review from a professional nutritionist. This service is not currently reimbursed by Medicare, but the restriction is I believe shortsighted. Provided with the strict medical necessity guidelines like our other professional services, nutritional counselling and support would hasten the healing process and or conserve strength for the patient, all important in keeping him out of the hospital.

In another related area, there is a critical need for which a mechanism has been designed, but it is so constricted that I believe wider use could create greater savings. The mechanism is the Waiver program.

The existing waiver programs of Medicaid (Medi-Cal) are funded 50/50 by the state and the federalgovernments, and could provide appropriate mechanisms to support the care of the aged and chronically ill. However, the limited scope currently authorized by the Congress seems to contradict the cost containment philosophy being addressed in these hearings.

These programs basically provide alternatives to expensive institutionalization with the cost cap being the institutional day rate i.e. acute hospitalizations, skilled nursing facility, intermediate care. The three programs: In Home Medical Care, Developmentally Disabled and Multipurpose Senior Service Programs, meet only a small portion of the need. We will review only two: In Home Medical Care and the Multipurpose Senior Services Program.

IN HOME MEDICAL CARE

This program allows for "shift nursing" to care for persons acutely ill but candidates for home care when medically stable. Diagnoses currently accepted are those patients requiring ventilator support who have an appropriate and safe home environment. The cost for institutionalization is approximately $760/day. Shift nursing using licensed vocational nurses under the direct supervision of a registered nurse costs approximately $500/day to cover twenty-four hours (Registered nurse care may be required in some cases). This is a savings of $260/day. Total equipment needs usually run $30/day; still a savings of $230/day. Only 215 patients can be served under this program for the entire State of California. By expanding this program to other diagnoses which may be appropriate to home care, with a cost cap of the acute, bed rate could generate an overall cost savings to both the Federal and State governments. Such conditions or diagnoses might include AIDS, dialysis, malnutrition requiring TPN, terminal illness, advanced end stage arthritis/scleroderma trach care, stage 4 decubitus, children with high technology needs requiring respite care and/or foster placement, catastrophic multi-system failure secondary to surgical interventions, toxic effects of treatment modalities, trauma victims requiring maximum system dependency on high technology nursing care. Expanding the scope and the number of patients to be covered would improve their quality of life, reduce costs, and utilize the acute care and critical facilities more appropriately.

As an illustration, a savings of $200/day over a 6 month period (some patients are on service longer) would save $36,000 times 215 patients resulting in a savings of $7,740,000. Program administration costs are not included in this figure. By maintaining control but shortening the discharge planning time and red tape involved (currently 4-6 weeks to evaluate and bid out for care) it is possible to stretch the taxpayer's health care dollar to meet the expanding long term care needs.

One of our contract hospitals has 2-3 patients per month with extended or indefinite hospitalization because the In Home Medical Care Program is backlogged by some 400 patients on waiting lists. Given the other major medical centers in Greater Los Angeles who could have a similar number of potential patients, the need for

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services is evident. Many more diagnoses could be served by these programs, increasing the potential for savings.

MULTIPURPOSE SENIOR SERVICE CENTERS

This program provides MSW/RN case management services to medically eligible persons over 65 who have no share of cost and who would otherwise have to be placed in a skilled nursing facility or intermediate care facility. The program organizes and tracks the most appropriate services necessary to keep these people at home. The major drawback is the number who can be served. Statewide the program can handle 5,400 clients at 22 locations. The State has requested an increase to 11,000 clients at 32 locations. Greater Los Angeles has four sites and can serve approximately 1,500–2,000 clients with proposed growth to six sites and 3,500–4,000 clients. This is a very limited availability with a population of 65 and over in Los Angeles county of more than 800,000 individuals.

Expansion of these programs to move more patients out of hospitals to their homes would reduce overall cost, relieve some of the pressure on the nursing homes, allow patients to remain at home and provide a more humane means for their care.

As for recommendations for future Medicare financing of home health service, I would offer several thoughts. The first is a cautionary word: DRG's as currently formulated are not an appropriate mechanism on which to base reimbursement for home care! In the hospital setting, the patient's diagnosis is the single most relevant indicator of his care needs. This is not true in the home. At home the diagnosis is only one factor (we use 28 others) in determining what the care needs are. These factors include such things as who the caregiver is and how able and available is she. Also, what is the patient's mental status—any diagnosis is complicated by impaired mental status when home care is dependent upon patient and caregiver being able to function safely between the nurse's visits. Also, the amount of teaching and education the patient and family need to cope effectively with the patient's condition, tubes, equipment, etc. can make major differences in home care needs between two patients with the same diagnosis. All the factors which can be controlled in a hospital setting can become controlling in the home care setting.

The National Association for Home Care (NAHC) is preparing documentation and a proposal for a prospective payment system for home care which would take into consideration the variables which make giving care in the home so different. The industry does not oppose prospective payment systems for home care as long as any such system is tailored for the special needs of home care and not just a hand-me-down from hospitals. As an agency and as an Association we look forward to working with Congress on a constructive, appropriate system for a prospective payment system for home health care.

Senator WILSON. Thank you very much, Ms. Grigsby.

Both Doctors Barbaccia and Reid have anticipated and rather fully answered our first question which was what effect has PPS had upon the delivery of health care, and what is the condition of patients leaving.

Lets sophisticate that question a bit and refine it. I think we have heard enough this morning so that it is clear that in 1983 when Congress moved to PPS, it was of necessity and yet it was not an intended result that we would short change anybody on care. We certainly were not seeking to create the impetus for a premature discharge.

Dr. Moncrief in his testimony said that he could understand how in order to implement a new system, it was necessary to put something into effect that was almost bound to be oversimplified. What we have apparently put into effect, was something that made actuarial sense but not medical sense since it was not flexible enough as it related to hospital stays, to take into account the difference in patient circumstance.

What you are saying is that your experience commonly has been that it has made for what has been termed sicker and quicker discharge.

I assume that both of you would agree that there is the need for a severity of illness component, and if there is one added, that you think—or I will simply ask you, if there is a severity of illness component added, do you think that this can adequately address the problem that you have described this morning?

Dr. BARBACCIA. I would say that the severity of illness component to better address the needs for more complex care in hospitals, will in fact reimburse or will meet those hospital needs more adequately. I think that it does not address, however, the posthospital needs that are also important in the patients who are sicker and have less ability to care for themselves and so forth.

I think that by introducing the severity of illness correction, better correction than we are currently dealing with, the hospital would be less pressed and less pressing to move out some patients who are currently now not paid for as well. I don't think that the whole problem would be solved accordingly. I can't be any more specific than that.

Dr. Reid, do you?

Dr. REID. Yes. I think it would only address the length of stay. I think it would not address the access and that is where I think that these rigid guidelines must take on the humanitarian, the social reasons.

In my written testimony I alluded to the review which they do routinely on patients admitted with pneumonia, and being called two months later to be asked why was this patient admitted. I couldn't recall this patient because it was my colleague's patient, so I said please read me the diagnosis—pneumonia, gastrointestinal bleeding and it was hypotension and not hypertension.

History of hypertension, and then I alluded to the fact that this elderly lady lived with her son who worked 50 hours a week. There is no place in the guidelines to take in social factors or this fact that we heard about, this poor woman who had to get up at 3 o'clock and come in at 5 o'clock for a morning surgery. I think there has to be a humanitarian, a social reason brought into the guidelines so that access can be for terminal patients.

Dr. BARBACCIA. I want to add just one additional thing, Senator, if I may.

I talked with our discharge planner at the University in San Francisco just a couple days ago. We talked about patients leaving the hospital, sicker and needing more care. I asked, what would be the most reasonable way that we could all work together in alleviating the problem. We agreed that for the first 48 hours, the first 2 or 3 days, that the patient is home from the hospital, are absolutely crucial. The patient needs not only the professional nursing services, but also assistance with personal care if there isn't family around to provide it.

That issue of that kind of care is something which is inadequately provided now by Medicare, and it will be a more important one as people discharged from the hospital require more care because of being sicker and so forth. So, I think the severity of illness issue would handle one part of it, but there is still a very, very major issue that needs to be answered.

Dr. REID. You must remember, Senator, that when these patients go home sicker than they use to be, that not all their care is ren-

dered by registered nurses, physical therapists. I happen to be one of the breed of many physicians who still makes house calls. These become more and more necessary and the responsibility of a physician when these patients go home sicker, is greater. There is more phone calls, there are more orders that go back and forth through the mail which must be signed and returned in 3 days. There is more liability involved, and you can't sometimes expect the visiting nurse to determine whether this patient needs a change in medication. You thus must make a house call which then deals with the anachronism of the physician being reimbursed less than the registered nurse for a home visit.

Dr. BARBACCIA. I think one interesting point that Ms. Grigsby brought up, should be emphasized. She talked about the amount of time the visiting nurse remains in home in any one day. When you think about it the period of time for the visit is 40–45 minutes. A question comes up that is absolutely crucial because of the importance of educating the family and others who are going to take care of that person. Who is going to be providing that patient monitoring and care in those other hours other than in those 40–45 minutes.

So I think it does point to the need for adequate support for those kinds of services at least initially—soon after the person is discharged from the hospital.

Dr. REID. I think we have learned from the hospice concept 1-that was alluded to here, and I think we should remind ourselves that this is a team concept, and the physician of course is at the head of this team, but we rely heavily on our social workers and our nurses and our home health aids, et cetera, to carry out a continuing good quality care which Mr. Fleming reiterated earlier today.

Senator WILSON. Ms. Worthen, let me ask you, do you think hospitals in California allocate sufficient resources, training and staff to discharge planning?

Ms. WORTHEN. I think the best way I could answer that would be to say that it probably varies. I am aware of hospitals that have 25 or 30 social service individuals who are doing discharge planning and other types of counseling, group counseling, supportive services to families. Then there may be other hospitals who are terribly short in terms of that particular function.

I think it varies a great deal, but the thing that I see happening is a growing need, I think the need for that type of personnel in the hospital is going to become even more apparent, and it may be that PPS in some ways has done us a favor by pointing out that there is this need for more people who can do the discharge planning function, and can do the very vital after care and followup function.

Senator WILSON. There has been a great deal of discussion this morning about informing the patient of his or her rights.

Is it unrealistic to suggest that perhaps the best way to do that is to have the discharge planner undertake that education and do so at the time of admission, or as it has been indicated, preferably at a preadmission stage?

Ms. WORTHEN. We have sort of assumed this function just out of necessity within our department, but we also have written informa-

tion available at the time of admission. I think that probably part of preadmission could very well be social workers or some other type of personnel, even at the admission level who would be able to do this.

You have so many aged people that do no hear well, they don't see well, they are not able to read the information even though all attempts are made at giving information, and it is always good intent to get it to people. You may just have people who are far too ill and who come in without any kind of social support, no family, no homemaker, no home aid, nobody with them and there is no one that they can turn to for interpretation.

So, I think your point is well taken. I would say, yes, if those kind of manpower hours were available, it would certainly be a good direction in which to go.

Senator WILSON. When you speak of manpower hours being available, what you are saying is, it is going to require some additional personnel?

Ms. WORTHEN. Yes. It would require a commitment to hiring social workers, additional people, some kind of financial incentive perhaps to the hospital, to upgrade in those areas to educate people, and to have people available for preadmission.

Senator WILSON. All morning long we have been talking about both cost and quality of care in attempting to reconcile what seems to be the conflict between the two.

Let me ask our two physician panelists whether or not they think that purely on the basis of cost, because you have been quite clear that the quality of care suffers when someone leaves acute care facilities sicker, and then goes on to require more extensive treatment and qualitatively a different kind of treatment than existed prior to PPS.

Is it your judgment that it is more expensive if one considers the entire continuing of care?

In other words, if we are saving at the acute care facility, apparently from what we are hearing from Ms. Grigsby, we are experiencing increased costs afterwards. Is the total more or less?

Dr. BARBACCIA. I think there have been several studies and that is the question for which no one has a good answer at the moment. I think we have some experiences with social HMO's for the elderly that provide the whole spectrum of services including case management. These have been shown to decrease the total amount of money required for the care of any one of those patients for a year.

One of the points that I have thought about, and I really don't have the answer to. If we are decreasing the number of days in any one particular hospitalization for an older person, are we also reducing the number of days over the whole year, that that patient would spend in hospitals? Does our shortened hospital stay in fact involve more admissions over time and more days of care in hospital over a specified time period.

I think that situation is a real possibility, and I have the impression that if we were to very carefully work out a plan of care for a person; knowing how to involve the family, knowing how to involve nursing services, the physician, the hospital and so forth, that by careful planning, by careful management of that full plan of care,

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we could decrease the amount of time in hospital and actually save money.

I don't think there is the evidence or data which would prove that; except as I say, from the social HMO situation.

I am convinced that if we will work together with the several disciplines in planning out care over a period of time, we could probably do that. I don't think there has been enough attention to do that.

Dr. REID. Theoretically, if we can reduce one hospital day, that might well pay for 2 or 3 days of extensive care at home. I think the New Jersey experience originally, showed a reduction in the total health care cost under the PPS-DRG, however, subsequently it has gone up.

Now, they did in the area of swing beds, they didn't have swing beds but they developed their own skilled nursing facilities, and one should not forget, the swing bed idea, I think, is a very worthwhile one. The hospital people brought this up. The reason the hospitals do not want to have the swing bed is because they are afraid to lose the acute licensed bed and never get it back. So swing beds are certainly something that might definitely reduce the cost because patients admitted on Thursday, never go home on Saturday or Sunday. If they are admitted on Friday, they never go home on Saturday or Sunday. If they are admitted on Monday, they may well go home on Thursday or Friday, so if they had swing beds where they no longer required acute care, and many nursing homes do not admit patients on Saturday or Sunday or Friday afternoon, these patients could receive a lesser expensive, but good quality care in the swing bed.

I agree that the data is not in, is this PPS really saving money in the long run.

Senator WILSON. From what you have just said and in particular from the comments that Ms. Grigsby made, I am wondering if I were to ask you the same question I asked Mr. Tibbitts, whether you would make a similar answer.

It seems to me that everything that we are hearing points to the HMO's as being able to provide that continuum of care that you have emphasized.

Dr. REID. My experience with our HMO-IPA reversed the usual statistics. Generally 60 percent of the premium dollar goes to hospital services, and 40 percent go to physicians and administrative costs. In our HMO this has been reversed, so 60 percent of the payout is going to physician services. But this again is dealing with the younger age group, the physicians are—it is tightly run. It was started by a physician. There is a certified hospital accreditation program so that there is precertification. The patient is reviewed daily while in the hospital, et cetera. So if this could be extrapolated in some way to the older age group, then I think HMO's type of health care practice might well reduce the cost.

Dr. BARBACCIA. I think the important thing is not an HMO or social HMO or a PRO, but a well defined system of care which includes the availability of continuing care, the appropriate level of services that a patient would need at a specific period of time. So rather than using hospitals, for example, one could substitute in

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home services, but of an intensity that would really meet the patient's needs, particular in this early time post hospital.

So we are really talking about a system of care which would have those elements that could be plugged in as appropriate. It would seem to me that we need that kind of a system, well organized, with its controls and so forth, I think it would be less expensive.

Senator WILSON. What you really need is flexibility to achieve that system, isn't it?

Dr. BARBACCIA. Right. You need flexibility not only in terms of availability of services, but also flexibility in terms of reimbursement. That is to say one should be able to really pay for services even though those don't absolutely meet the criteria for indications of that service through Medicare as it currently exists. You need some flexibility in terms of criteria of choosing services.

Senator WILSON. For that reason, Doctor, doesn't capitation give you a very considerable advantage as a health care planner and as someone responsible for the delivery of health care services? In planning that system, and particularly as it relates to the obvious need of elderly patients, with a far greater range of ancillary services, isn't the HMO or call it what you will, the system approach, and one that is funded under a capitation approach, a great deal more tailored to the peculiar needs of the elderly patient?

Dr. BARBACCIA. Senator, I would answer it this way. I think that a system which used capitation could in fact do what we are talking about in terms of reduced cost and provide appropriate services.

The important thing would be that the capitation level be appropriate so that there would be incentives for people to participate in this kind of a system; reimbursement for specific services would be reasonable.

Dr. REID. There must be tight controls on the utilization end. I think the experience in this city where the poor were denied checkups for their blood pressure and diabetes, subsequently resulted in increased morbidity and mortality; proof that preventive care does work. But if you deny access because of the system, then I think you must deal on the other end with a more seriously ill patient.

Senator WILSON. Let me just ask this last question of Dr. Barbaccia in particular, and Dr. Reid as well, is a question I earlier asked Dr. Moncrief.

Is the medical profession and specifically, medical education, developing a sufficient number of what I think are correctly termed, geriatrician, those who are specifically educated to care for the peculiar problems of the elderly?

Dr. BARBACCIA. When one looks at the number of physicians in the country who claim geriatrics as their primary specialty, it amounts to much less than even one-half of 1 percent of physicians in the country. There aren't very many now in any city or rural areas.

The fact remains, however, that the task of geriatrics remains for family physicians, for internists, general internists, and to some degree, psychiatrists and others.

I think there has been a big lag of interest in the medical schools and in the profession of training geriatricians. But I think as I see

it now, that a number of groups such as the Association of American Medical Colleges have really tried to stimulate the medical schools to respond to this need.

The National Institute on Aging has done likewise. In California, the State legislature, has made available to the University of California, some funds to stimulate the medical schools and the health science campus to train geriatricians.

I was called the other day about two fellowships that were available in a nearby VA Hospital for the training of geriatricians in a 2-year fellowship program.

I think at the moment we are not doing as much as we should have been doing. Yet we are really gearing up to do a lot more in terms of education, not only of geriatricians, but in my own academic unit, the University of California, our intent is to train family physicians to be aware of the problems of older patients, to be aware of the kinds of problems that we have been discussing today that exist in the delivery system when you are dealing with elderly patients. We realize that many family physicians and internists and not geriatricians, will be providing health care to the elderly.

I would like to see the development and training of geriatricians, but I also think it is going to be very important that general internists, family physicians, and some psychiatrists, be prepared accordingly.

Dr. REID. I would like to speak for the specialty of internal medicine. We feel that geriatrics is a unique part of the specialty of internal medicine. We do not want it to be split off as a specialty all of its own. We do support the development of departments of geriatrics within the departments of medicine, or if you would have a division of geriatrics.

One of the important things in medicine is the continuity of care. Patients start with you at the age of 12 and if you live long enough, they may well be with you in the Medicare years.

Senator WILSON. Let me ask a final point. I would gather from just the comments that were made as part of this television program to which I have alluded this morning, that it is not enough simply to increase the availability of education in the medical schools. The question is having led the horse to water, will they drink, and a point was made that a surgeon who conducts a 15-minute procedure for which he receives $1,500 to $2,500, is far better compensated for his time than a geriatrician who spends four times that amount of time and can charge $30-35-50?

That is a very real and very human problem, and it is one that calls into question are we to compensate physicians for time or for skill or how do we reconcile that.

I would be interested in your thoughts.

Dr. REID. This of course is alluding to the cognitive issue versus the procedural issue, and the feeling that for many years the procedures have been reimbursed approximately 4 to 1 over cognitive. Not to say that surgeons do not think, but those of us who spend time and listen, we all do some psychiatry, we do counseling, this should be appropriately reimbursed. How can you instruct a new diabetic, age 70, in diet, all in 15 minutes. You cannot. But if you are not reimbursed for the 45-60 minutes you spend, then the pres-

sure is not to spend that time and the patient does not get the advice that they should get.

So I think the efforts HCFA has at the American Medical Association request, is looking into studying this and Harvard is going to do a study to verify the impact of changing the reimbursement system to more appropriate reimbursement for cognitive services.

Senator WILSON. Thank you very much.

Dr. Barbaccia, Dr. Reid, Ms. Worthen, and Ms. Grigsby, thank you for your time and your generosity with the effort that you have made to participate, we are very grateful.

That concludes this hearing; we are adjourned.

[Whereupon, at 1:17 p.m. the Special Committee on Aging was adjourned.]

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APPENDIX

MATERIAL RELATED TO HEARING

KAWEAH DELTA DISTRICT HOSPITAL
A NON PROFIT COMMUNITY DISTRICT HOSPITAL
400 W. Mineral King, Visalia, CA 93291
(209) 625-2211

THOMAS M. JOHNSON
EXECUTIVE DIRECTOR

January 2, 1986

Mr. Will Bishop, Vice President/Finance
California Hospital Association
1023 12th Street
Post Office Box 1100
Sacramento, California 95805-1100

Dear Will:

In response to your questions regarding your meeting for Senator Wilson, on January 7, 1986, below are my comments regarding those particular issues.

The need to eliminate the three-day hospitalization before patients can be admitted to a Skilled Nursing Facility completely ignores two factors involved in Health Care today. First is the cost issue, if a patient is not at an acute local care facility, they should not be placed into a hospital just to meet the requirement of being admitted to a SNF. This is a waste of three days of hospital revenue, and is an inappropriate use of the hospital facility. Secondly, that admission when reviewed by the PRO will probably be denied because of lack of medical necessity of admission. That goes against the hospital's individual waiver status. It seemed to me that under the new changes in the reimbursement system that there can be criteria established for direct admissions to Skilled Nursing Facilities.

When a patient is getting ready for discharge from our hospital, for instance, we believe that part of their patient's rights is to let them know all of the options available to them in terms of facilities available and alternate methods of care, such as Home Health. Our Social Service Department does an excellent job of continuously informing the patients and family about their options when the patient is discharged. We will be starting a program early in 1986 called Pre-admission Discharge Planning where, in fact, a lot of this counseling will go on prior to the patient even coming into the hospital so that they will know what to expect upon discharge.

The issue of premature discharges is one that mystifies me knowing physicians and working on Medical Staff committees over the course of the years. The only premature discharges, in my opinion, that I

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have ever seen are those forced on us by people such as MediCal and under the old cost reimbursement system, Medicare, where patients were asked to leave despite physicians' opinion. Currently, under DRG's, there is no pressure at all to discharge patients despite the fact that they might be an Outlier or a non-profitable DRG. Perhaps the problem here in premature discharges is two things:

1. Patients misunderstanding their rights under the Medicare Program thinking that they can stay in the hospital as long as they would like because they are entitled to benefits.

2. Pro-profit hospitals and pro-profit corporations needing to increase revenue, therefore, providng a lot of pressure to physicians to discharge those patients earlier than need be.

I can assure you, in the Central Valley, I do not see any of that occurring at all. In fact, physicians are doing everything that they can possible for the patients at this point in time, regardless of their financial status.

Regarding DRG's for SNF beds, I think that eventually some type of prospective payment will be in place for all health care facilities; and I see the SNF's not having any particular reason not to be included in that system. However, I think putting physicians on DRGs is a much more acute need and needs to be dealt with prior to SNF's.

The accessibility of SNF's and ICF's continues to be a problem, I think, throughout the nation. Hospitals should be allowed to use more areas of their facility with the unoccupied beds as "swing" beds and there should be encouragement of building sub-acute care facilities as well to move those people out of acute care as soon as possible. However, there is no incentive for increasing SNF or ICU or Sub-acute when the reimbursement rates are so low and barely cover any types of costs involved, and the quality of care there then is not as good as it can be. As a result, physicians are less inclined to discharge people to those facilities that are lower cost. So, there is kind of a non-incentive to use those facilities while there should be an incentive to use those facilities and to build new ones.

Monitoring systems that we use at Kaweah Delta for monitoring re-admissions is a fairly intense and sophisticated one. Through three areas of our hospital, we monitor re-admissions. One is through the Risk Management area where they look for problems; second is through the Quality Assurance function that uses generic screeing and identifies all re-admissions, and those re-admissions are then sent to clinical committees for review of appropriateness; and, third, the Concurrent Review System in our hospital will identify inappropriate re-admissions and those brought to the attention of the Utilization Review Chairman. We find, often, the cause for re-admissions is lack of patient compliance and that continues to be a

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concern of ours and an area to address in the long run.

Regarding the preferable method on Part B Reimbursement, I mentioned earlier that I thought that physicians needed to be on a DRG type system, and I guess this would apply to Part B where they are not included in the hospital payment, if you will, but would be given a flat rate. So, there is no incentive for them to continue using hospital facilities when the patients no longer needed in the hospital.

I hope this helps answer your questions, Will, about these particular issues. I hope that it is some help to you with your discussions with Senator Pete Wilson.

Sincerely,

KAWEAH DELTA DISTRICT HOSPITAL

Melanie M. Minarik /s

Melanie M. Minarik
Director of Administrative Services

MMM:jac

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714 P STREET
SACRAMENTO, CA 95814
(916) 322-5824

January 3, 1986

The Honorable Pete Wilson
The United States Senate
Attn: Nancy Campbell
11111 Santa Monica Boulevard
Los Angeles, CA 90025

Dear Senator Wilson:

Thank you for the opportunity to submit comments for the hearing conducted by the U.S. Senate Special Committee on Aging. California is proud to have established a long-term care (LTC) system which serves the medical needs of our frail, elderly, and disabled persons in a sensitive and efficient manner. These citizens are assisted and cared for from the moment they are ready for discharge from an acute care hospital. We believe that the continuum of LTC services provided in California are as comprehensive as any available in the country.

According to data gathered by the Department of Health Services, most LTC admissions in California occur following an acute care hospital stay. As you are aware, California negotiates contracts with hospitals which serve Medi-Cal patients. Contracting with hospitals has eliminated costlier fee-for-service billing and has substituted lower cost daily hospital rates applicable regardless of the patient's diagnosis. When the patient no longer needs the acute level of care but instead requires skilled nursing, the patient is transferred to a skilled nursing facility (SNF) or to other care services. When those are not available the patient may be transferred to a distinct-part SNF (if one is operated by the hospital) or the daily rate to the hospital is reduced to the "administrative day" rate (to reflect the lower level of care needed) until a freestanding LTC bed is found.

Home Care

Patients about to be discharged from an acute care hospital should receive the most appropriate LTC services. California has instituted an experimental project whereby Medi-Cal applicants to nursing homes and other LTC facilities are prescreened prior to admission to determine whether they are eligible for and desire to participate in one of several LTC home and community-based care programs. There are three such programs currently in operation through federally approved Home and Community-Based Waivers and proposals have been submitted to obtain waivers for two additional programs. Currently approved federal waiver programs are as follows:

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1. Developmentally Disabled (DD) Persons -- provides home and community-based services to DD persons who would otherwise reside in an intermediate care facility (ICF) for the mentally retarded. The waiver is directly administered by the Department of Developmental Services and provided services to approximately 3,600 persons during the first three years of the waiver. During the first two years the waiver resulted in a savings of $6.5 million in state and federal funds. A request to extend the waiver for three additional years is being reviewed by the Department of Health and Human Services. These services allow DD persons, who in past years would be relegated to state hospitals and large institutions, to live in the community in a home-like environment and still receive necessary services.

2. Frail Elderly Persons -- provides home and community-based services to persons who otherwise would reside, or be at risk of residing, in SNFs and ICFs. The waiver program is directly administered by the Multipurpose Senior Services Program (MSSP) within the California Department of Aging (CDA). Under this waiver 5,400 frail, elderly (65 years of age or older) persons may be served during the first three-year approval period. A savings of approximately $325,000 in state and federal monies has resulted from the first two years of the waiver. The waiver expires June 30, 1986, and the CDA has recently submitted a request for a new waiver which would serve a maximum of 16,263 persons by 1989. MSSP contracts with 22 case management sites throughout the State. The case managers assess the needs of eligible clients maintain a plan of care, and arrange for the necessary services which may be funded by several sources such as Title III of the Older Americans Act, Medicare, Title XX Social Services, and the Home and Community-Based Waiver authorized by Title XIX Medicaid Act.

   The case managers monitor the clients in an attempt to keep them at home rather than in a nursing home. This is not only more desirable from the viewpoint of the client and family members but is less costly to Medi-Cal.

3. In-home Medical Care Program -- provides skilled nursing and other home and community-based services to physically disabled persons of all ages who, otherwise, would reside in acute hospitals for long periods of time because their care needs are more intensive than nursing homes can accommodate. The program is directly administered by the Department of Health Services and due to a recently approved amendment may serve up to 200 persons by the end of the third year. The waiver is effective through June 30, 1986 and a three-year renewal will be requested. The first two years of operation have resulted in savings of $24 million in state and federal funds.

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Institutional Care

If it is determined that a LTC facility is the most appropriate placement, there are Medi-Cal certified facilities at various levels of care which are tailored to fit the individual nursing needs of specific patients.

Subacute Care

In addition to the ICF and SNF level of care which have been available for many years, the State is now developing within the SNF arena a level of very intensive licensed skilled nursing care, which we will call subacute. Although this classification is still in the development stage, once approved, subacute facilities would provide intensive licensed skilled nursing care to patients who are fragile but still medically stable. The subacute program will be implemented initially on a limited basis in freestanding SNFs and in hospitals with distinct-part SNFs. Licensed facilities which provide this level of care will be an ideal resource for acute hospitals which have a "discharge ready" patient that is hard to place because of heavy licensed nursing care needs.

Intermediate Care

At the intermediate care level, California has specialty categories. In 1982 the Legislature created a new type of facility called "intermediate care facility for the developmentally disabled-habilitative (ICF/DDH). These are small community facilities with a capacity of 4 to 15 beds. ICFs/DDH provide a home-like environment for the DD clients who do not require continuous skilled nursing care and who have no behavior problems which require services of larger institutions.

Additionally, we are in the process of implementing state legislation which created the intermediate care facility for the developmentally disabled -- nursing for DD individuals who are medically fragile or demonstrate significant developmental delay. These facilities will be similar to the ICF/DDH but will have increased staffing ratios to accommodate the greater care needs of the client.

Health Care Utilization Review

One aspect of the program of which California can be especially proud is the method by which we perform health care related utilization control. California has gone to great lengths to assure that Title XIX funds are spent appropriately for medically necessary services. For many years these controls have operated under a "superior system" waiver granted by the Secretary of the Department of Health and Human Services to accomplish utilization review.

This system superiority is borne out by the success of Medi-Cal in controlling unnecessary and excessive utilization. For example, In California, many services are prior authorized to determine medical necessity. State-employed physicians and registered nurses use professional judgement as well as standardized written criteria to make these decisions. In addition, the Medi-Cal fiscal intermediary institutes prepayment control by reviewing all claims submitted for payment to ascertain whether benefits were authorized by a Medi-Cal consultant and whether the necessary documentation is attached.

Finally, postservice, postpayment controls are utilized. The Medi-Cal fiscal intermediary develops profiles of providers and compares their overall performance against standards and norms to identify apparent program abuse. Questionable practices are investigated and where abuse is identified, action is taken against providers or beneficiaries.

Considering the wide range of services available to Medicaid LTC recipients and the efficient handling of Title XIX funds, California has set an example for other states to follow. The cooperative efforts of the LTC industry, the public, and the State since the inception of Medicaid have brought LTC beyond good intentions to tangible services.

Please feel free to contact me at (916) 322-5824 if I can provide additional information.

Sincerely,

John Rodriguez

John Rodriguez
Deputy Director
Medical Care Services

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VAMC WEST LOS ANGELES
Brentwood Division

Statement of Associate Chief of Staff for Education
for Congressional Hearing on the Effects of DRG's
on the Geropsychiatric Patient.

There is a concern, with the implementation of the DRG Program, that this does impact on the quality of care in certain areas of psychiatric activity. Here at Brentwood, we have a number of programs, which by their very nature, require an extended hospital stay in order to meet the Goals and Objectives associated with the care of the patient. I want to briefly discuss these and try and make clear why the extended length of stay beyond the DRG trim points is essential, and why, if we are to remain within the DRG trim points, the very nature of the program is distorted to the extent that we may not be able to meet the objectives of the program.

The first program I want to mention is the TAC, the Total Abstinence Colony, which is a drug free program for heroin and other drug addicted patients, which has been in operation here for about seven or eight years under the supervision of Dr. Charuvastra This is essentially a therapeutic community program where the patients have remained for periods nearly up to a year. And in early follow-up work that was done several years ago, Dr. Charuvastra followed these patients after discharge for periods up to three years, and found that a substantial proportion of these patients had remained drug free. This is an excellent result compared to an untreated population, and justifies the continued existence of the program. The reduction in length of stay for the patients of this program makes it highly questionable as to whether the initial objectives to attain a drug free post-hospital result can be attained. The development of a drug free lifestyle, and the development of personality strengths which enable the individual to resist the use of drugs cannot be achieved in a short hospital stay.

The second program I want to mention is the 205C Program, which is one set up for the treatment of personality or characterologically disordered patients. This program was set up in response to the experience within the Brentwood Hospital that personality disordered patients were not receiving benefit from their stay in general psychiatry wards; and were, in fact, disruptive both to staff and to other patients, because they simply did not adjust to the milieu which is suitable for a severely disordered neurotic or psychotic patient population. Many of these patients have antisocial character traits and have a history of arrests, not just once, but a number

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of times. This program was set up in order to essentially retrain or reform the major personality behaviors of these patients. This required an extended period of association with the program environment and with the Goals and Objectives of the program. The length of stay was somewhere in the neighborhood of nine months in the past, and this has been drastically shortened. Again, the question arises whether it is possible to attain the results which were previously achieved with a drastically reduced length of stay in hospital. In determining costs which the DRG philosophy is primarily concerned with, I think one has to be aware of the fact, that if a patient leaves hospital as a therapeutic failure, then society must experience the cost of that failure in terms of continuing antisocial behavior, and the use and misuse of other health facilities and correctional institutions.

The third program is the Geropsychiatry Program. Dealing with elderly patients who have multiple medical problems, at the same time as psychiatric difficulties, provides a population which requires a prolonged length of stay, not only because more careful and general investigative procedures are required, but because the elderly tend to respond with slower healing to therapeutic interventions than is true for the younger population. The particular environment in 209A is not only serving the special needs of this population which were not otherwise well served by the general psychiatry environments, but is also providing an opportunity for the training for professional workers in this field. This meets an acute need in dealing with the rapidly increasing geriatric population of the nation, and in addition to training, provides a population for investigative work and research which is a critical need to meet and solve the problems which are peculiar to this particular population.

The last special program that I want to mention is the IRU, which stands for the Intermediate Resocialization Unit. This provides an additional hospitalization or a protected, sheltered environment for a number of patients who have achieved recovery from their acute psychiatric illness, but are not yet able to leave the hospital and reenter the community with any degree of success. If they move to the IRU and have the security of the sheltered and supportive environment, they are encouraged to develop resocialization skills and to venture into the community job market, and to establish themselves on a surer footing while they still have the support of the hospital environment and staff. This serves a very important need for those patients who, if they are returned to the community as soon as the acute illness period has subsided, will again fail to meet the stresses of their community life. This leads to relapse and return to hospital in a continually deteriorating cycle of health and personal competence on the part of the patients. This program serves a need which helps to prevent the relapse into acute illness and rehospitalization.

These four, the TAC Program, the 205C Program for characterologically disordered patients, the Geropsychiatry Program, and the IRU, are programs which were specially developed and designed in order to meet the needs of selected populations among our psychiatric patients which were not previously being well enough met by acute hospitalization or by the general

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psychiatry services. It's our hope that the implementation of the DRG and the push to reduce length of stay will not lead to the destruction of these programs, because the quality of our services to our veteran population will be less than optimal.

MANUEL STRAKER, M.D.
ACOS/Education/Quality Assurance
1/4/86

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Veterans Administration

Memorandum

Date: January 6, 1986

From: Chief of Staff, Brentwood Division (B111)

Subj: DGR - relevant information

To: AACOS (B11D)

1. The following observations reflect the difficulty of applying DRG criteria to the current 2NB/C population (composed largely of geriatric age and brain-injured patients):

	Randomly Chosen Weekly Population			
	12/30/85	11/18/85	10/21/85	9/23/85
Unplacable because of behavior difficulty	4	6	5	4
Unplacable because of recurrent medical problems	3	2	3	3
Total unplacable patients	7	8	8	7

The total possible 2NB/C population is 30; thus approximately 27 percent of this group of patients is unacceptable to any community nursing facility. Provision of needed care to these patients is penalized under the DRG system.

JEFFREY L. CUMMINGS, M.D.
Chief of Medicine, Brentwood Division

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January 7, 1986 (Revised)

Testimony Before Senator Pete Wilson on
the Effects of DRG on the Geriatric Population
by Lissy Jarvik, M.D., Ph.D.

Senator Wilson, and Members of the Panel:

My name is Lissy Jarvik. I am Chief of the Psychogeriatric Unit of the Brentwood Division of the Veterans Administration Medical Center West Los Angeles, as well as Professor of Psychiatry at UCLA and Chief of the Section on Neuropsychogeriatrics at UCLA's Neuropsychiatric Institute and Hospital. In addition, I am an appointed member of the State of California Alzheimer's Disease Task Force created by Governor Deukmejian, Immediate Past President of the American Association for Geriatric Psychiatry, and Vice Chair of the national Medical and Scientific Advisory Board of ADRDA. I am pleased to appear before you today as a physician who has worked with older Americans for over thirty years.

I know that there are very healthy older Americans in their seventh, eighth, and ninth decades of life -- and even beyond. But I also know that the oldest patients tend to be among the sickest patients with the slowest recovery rate, who suffer from multiple medical as well as psychiatric problems, requiring the most resources -- in terms of health care, psychological support, fiscal aid, and social network -- while having the least, i.e., no job, dwindling financial resources, shrinking nuclear family, and diminishing number of friends because of death and reloca-

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tion.

The illnesses prominent in old age are usually not service-connected, although they may aggravate service-connected conditions. The elderly veteran who makes it into a V.A. facility tends to be frail, vulnerable, and to have exhausted all readily available resources. Many of the patients we see in Psychogeriatrics personify the spectre of the overmedicated, spaced out zombie; many others would not survive without the 4, 5, 6, 8, and even 10 costly medications they consume each day.

Under DRGs, they are among the most undesirable patients: costly care, long-term care. No one wants to admit them, no one wants to treat them, no one wants to keep them. If admitted to a hospital, they are likely to receive the least amount of clinical investigation -- though they may need the most; all efforts are concentrated on getting them out; they are discharged too soon, too sick, to facilities not equipped to accept them or care for them. No wonder they are likely to have a relapse, end up even sicker than they were initially, and require even more of our costly acute care resources. This constitutes fiscally bad management. And, equally, it constitutes morally and ethically bad management, when we consider that it is our veterans whom we repay in this fashion. Denial of hospital admission, inappropriate and premature discharge, these will be the rewards reaped by those who in their youth willingly risked their all to save our Nation and everyone of us. They deserve better; we deserve better.

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CALIFORNIA HOSPITAL ASSOCIATION

TESTIMONY

MEDICARE PRO REVIEW PROGRAM

SENATOR PETE WILSON

JANUARY 7, 1986 - LOS ANGELES

I am John Ferman, Senior Vice President of the California Hospital Association. The California Hospital Association is pleased to comment on the following questions submitted by you.

Question 1: What would you foresee as the benefits of eliminating the three-day prior hospitalization requirement for SNF benefit? Might this have adverse effects on any healthcare provider group? How might Medicare beneficiaries be affected?

Response: Patient treatment patterns should be consistent with the most appropriate level of care required and services necessary on a case by case basis. It is important to eliminate the fragmented health delivery system caused by regulatory agencies and reimbursement policies.

CHA recommends:

1. Patients should be admitted direct to a facility which can provide the appropriate level of care.

2. Admitting standard and guidelines be established for direct patient placement to a non-acute facility.

3. Eliminating the current three-day acute stay prior to SNF admission.

Question 2: What is common practice in hospitals regarding patient (particularly Medicare) education as to "their" rights regarding timing of discharge and their post hospitalization placement?

Response: Under the Medicare program hospitals utilize discharge planners in assisting with an ongoing patient education and case management program. Although not required, many hospitals extend this program to all patients regardless of their source of payment. These are additional costs to the institution which have been incurred since the commencement of the Medicare program. Medicare patients are still confused as to their rights, benefits, and their payment requirements.

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CHA recommends:

1. An improved patient communication program be implemented which clearly outlines the various responsibilities of providers, beneficiaries and the PRO.

2. Clearly assigning the responsibility for carrying out the communication program, i.e., HCFA, PRO, and provider.

Question 3: What knowledge do you have of Medicare patients being prematurely discharged from hospitals as a cost-saving measure on the part of hospitals? (Before discharge is medically indicated.) Who are the guilty parties in these premature discharges--the hospitals, the intermediaries or the physicians?

Response: CHA has no evidence of a trend toward premature discharges. California's length of stay has always been shorter than the national average and like the rest of the nation has shown decline in length of stay over the past three years. Our data reveals that the length of stay is beginning to level off and further declines are not projected. Many hospitals have more problems gaining approval for day outliers than for early discharges.

Question 4: Since many hospital systems now have nursing home facilities, what is your opinion on the value of developing a DRG system for skilled nursing facilities (SNFs)?

Response: Hospitals should not be caught in the middle from their inability to place patients either due to a lack of SNF beds or the reluctance of SNF facilities accepting patients because of inadequate reimbursement. Before considering a DRG program for SNFs more evaluation and review of the hospital DRG program should be undertaken. There still remains many inequities in the current hospital program which should be eliminated when considering a SNF DRG.

CHA recommends:

1. SNF DRG system not be instituted until a thorough review of the current acute DRG program has been done and modified where inequities appear.

2. The collection of detail data from the hospital based and free standing facilities.

3. If a program is developed it should be on some pilot basis.

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Question 5: Explain your opinions on the accessibility of sufficient SNF and intermediate care facility (ICF) beds. What do you see as possible solutions?

Response: It is recognized in California there is a lack of available SNF and ICF beds, particularly for Medicare and Medi-Cal patients. The reasons include, lack of adequate reimbursement and many SNF and ICF facilities not wishing to receive patients who require more than custodial care. It has been said that there is no shortage of beds for the private paying patient. There is often long delays in finding available sub-acute care beds and often to the expense of the hospitals.

CHA recommends:

1. An appropriate reimbursement system be developed consistent with the level of care provided and required.

2. That the reimbursement program include a continued evaluation of methods to encourage the appropriate level and payment for sub-acute levels of care.

Question 6: Explain your monitoring systems for utilization review which would discover patterns of patients being readmitted to the hosptial to die after a prior discharge. Do you monitor costly stays and physician treatment patters? What is done with doctors who are offenders?

Response: There has been an unwarranted attack on hospitals accusing them of prematurely discharging patients as a cost saving measure. As previously mentioned hospitals have instituted costly patient monitoring and case management measures to assure that appropriate utilization and quality of services has been provided to all beneficiaries. CMRI, the California PRO, has stated their data does not indicate hospitals are abnormally discharging patients too soon. The PRO contract requires them to review all admissions occuring within seven days of discharge and denies all claims for inappropriate or unnecessary admissions. The PRO contract for 1986-88 expands this requirement to 15 days.

Question 7: Please comment upon which method of reimbusement would be preferable in your view with regard to "Part B" Medicare services. Your views will be convened to the administration and to the Finance Committee, as well as to the Senate Special Committee on Aging.

Response: Payment policies for Part B Medicare services should include the following:

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1. A propsective system for physicians should take into account regional differences and variations in treatment patterns.

2. Payments for physician services should be made directly to the physicians or to an entity established by the physicians.

3. Incentives for hospitals and physicians should be parallel and consistent.

We are pleased to attach an executive summary of a report on the PRO Program prepared by the California Hospital Association and California Hospital Association Joint Oversight Committee.

Attachment

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Executive Summary
of Recommendations

The Congress should:

- Evaluate the impact of PRO review on quality of care and patient outcomes.
- Reconsider any arrangement that would make PRO contractors unofficial agents for rationing health care.
- Ensure that all PRO physician members are adequately represented in setting policies and protocols.
- Evaluate the cost-effectiveness of the PRO program.
- Discourage imposition of increased review burdens on providers.
- Evaluate whether costs are being reduced or merely shifted from inpatient to ambulatory of SNF care.
- Require HCFA to develop long-term policy based on patient care data.
- Prevent HCFA from taking regulatory actions which contravene state law regarding confidentiality.

HCFA should:

- Prohibit use of taxpayer funds to subsidize private-sector review.
- Evaluate methodologies for setting up quality and admissions objectives.

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- Cease forcing quantitative measures of quality when possible.
- Ensure that quantitative targets and their baselines are set or validated by an independent body.
- Ensure a computational trail if targets or baselines are changed.
- Redesign reports and instructions to facilitate analysis and interpretation.
- Determine whether the primary function of PROs is peer review, policeman or gatekeeper.
- Ensure that standards of medical practice are integrated into review protocols.
- Ensure that PRO resources are not consumed on readmission review across PRO boundaries.
- Pursue its intent to develop a mechanism for exempting "good performance" providers.
- Endure that diagnosis/procedure targeted review is not expanded without evidence of need.
- Ensure that review criteria not set defacto new medical standards.
- Ensure adequate opportunity for comment on new regulations.

<u>CMRI should:</u>

- Improve communication with beneficiaries and providers.
- Develop a mechanism for coordination of reconsiderations.
- Arrange delegated review for qualified hospitals.

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RESUME

JOHN H. FERMAN
1023 12th Street
Sacramento, CA 95814
(916) 443-7401

1974 to Present - California Hospital Association

The Association serves and represents the interest of approximately 500 member hospitals. Programs address public policy and regulatory issues, insurance, legal issues, financial and personnel management, management effectiveness, hospital governance, hospital volunteer programs and research and development.

July 1974 - April 1978 - Management consulting and education.

April 1978 to Present - Various positions in Government Relations, currently:

Senior Vice President - Duties Include:

1. Managing and directing the programs and personnel of the Government Relations Division.

2. Development of legislative positions for the Association.

3. Serving as the Association spokesman in legislative and regulatory areas and as principal witness before committees, agencies and commissions.

4. Insuring competent and effective staff through organization, selection and development of high caliber employees.

5. Providing effective liaison between the Association and the membership through active leadership on various committees and task forces.

6. Promoting and influencing an appropriate position on regulations pertinent to California hospitals at the Federal level through direction of, and active involvement in, the Federal Relations program.

Professional Affiliations

Member, American Hospital Association
Member, Health Care Executive of Northern California
Nominee, American College of Hospital Administrators
Member, Sacramento Health Care Management Association
Member, American Public Health Association
Associate Member, National Health Lawyers Association
Honorary Member, Hospital Management Systems Society, Southern California Chapter, 1981

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Testimony Prepared

for

United States Senate

Special Committee on Aging

Inquiry into Medical Care for the Elderly

Field Hearing

Los Angeles, California

January 1986

by

Jacquelene R. Lee

Health Systems Specialist

Veterans Administration Medical Center

West Los Angeles

Brentwood Division

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TESTIMONY PREPARED FOR THE UNITED STATES SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING

It is my pleasure to address some of the issues raised by the impact of the prospective payment system upon health care provided to our veteran beneficiaries. It is my understanding that concern has been expressed by the Senate Special Committee on Aging relative to the continued implementation of the perspective payment system. These concerns have focused on: 1) whether the post-hospital care component of the medical care delivery system is prepared to receive patients now being discharged from hospitals earlier than in the recent past, 2) the degree to which patient care may be compromised in order to meet Diagnostic Related Group (DRG) length of stay requirements, 3) education and training efforts for staff working with the geriatric population, and 4) hospice care.

These concerns are genuine, and I believe, warrant continued investigation. At this point in time, we are all aware of anecdotal and actual cases where patient care has been compromised in the medical/surgical areas. As you are aware private and nonprofit free standing psychiatric units/hospitals are currently exempt from application of DRG's. California is one of the leading Peer Review Organization States and many cases have been found which warrant review for sanctions. Federal sector hospitals have only recently come under the prospective payment system, therefore, we do not have the exposure experience that the private sector has had. However, the VA health care system has implemented all DRG's including the psychiatric DRG's at all VA facilities. We have noted a number of different events occurring which I'd like to address at this portion of testimony. Our experience, since implementation of the prospective payment system in the private sector, has been that the veteran beneficiaries seeking admission into Veterans

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Administration hospitals have been a sicker, more medically compromised population. We have also seen an increase in the number of patients seeking VA admission, who formerly had been cared for by county hospitals, which, because of funding cuts, are no longer able to treat the same number of patients. Therefore, they are referring veterans to a VA hospital for treatment. We have also noticed an increase in the number of homeless veterans applying for treatment.

A brief description of veteran patients, with particular emphasis on the geropsychiatric patient, would be useful. The typical veteran psychiatric patient has few intact family support systems. He/she generally works or has worked and been in the lower socioeconomic strata, and has generally been removed from societal mainstream. Additionally, since this is primarily a psychiatrically compromised patient population, we find that there has been a general deterioration in health based on a lack of physical care, poor nutrition, and frequently, multiple substance abuse problems, in addition to the underlying psychiatric disorders. A significant proportion of our patient population is homeless.

The VA maintains many patients who have had difficulty receiving treatment and/or placement in the community. These patients occupy needed acute beds costed to the DRG model. These patients have Alzheimer's Disease and related dementing disorders, epilepsy with behavioral complications, movement disorders including tardive dyskinesia, Parkinson's Disease, Huntington's Disease, episodic dyscontrol syndrome, organic delusional syndromes, organic affective disorders, organic hallucinosis, and organic personality syndromes. These behavioral syndromes typically result from degenerative disease, trauma, stroke, and neoplasms. Again, this is a patient population for which it is difficult to obtain care in the community.

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We established a geropsychiatric program at Brentwood approximately twelve years ago, because we forecast the aging trend, and found that our current geropsychiatric patients were not getting optimal care on other wards. There was little known, at that time, about psychotropic dosing and drug interactions in the aging patient. The complex nature of a research/teaching/medical geropsychiatric program does require an extended hospital stay, which is necessary to assure adequate medical and psychiatric care, not only because more careful and general investigative procedures are required, but because the elderly tend to respond with slower healing to therapeutic interventions than is true for the younger population. The particular environment in our Brentwood geropsychiatry ward is not only serving the special needs of this population which were not otherwise well served by the general psychiatry environments, but is also providing an opportunity for the training for professional workers in this field. This educational experience meets an acute need in preparing professionals to deal with the rapidly increasing geriatric population of the nation. In addition to training, it provides a population for investigative research which is critical to meet and solve the problems which are peculiar to this particular population. If the program is to remain effective, the DRG length of stay norms for these particular geropsychiatric patients must be modified. It should be noted that few of these patients are experiencing their first or second psychiatric admission, since multiple past admissions are the rule.

There are 4 types of older psychiatric patients that I would like to mention: the organically disabled, the wandering patient, the chronically assaultive patient, and the noncompliant patient. These groups of patients are interrelated. They are not diagnostic groups. They describe problem behaviors that require protective care. These are patients that develop only limited insight and understanding of their behavior.

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The organically disabled are patients that may have a variety of diagnoses such as Alzheimer's or other dementias. A small number are patients that received lobotomies years ago. They are gravely disabled. They do not have sufficient judgment to handle their own care needs. Many do not have families to plan their care. If these patients are discharged with poorly thought-out plans they become some of the "homeless" that crowd our streets. These patients need congregate care that provides for their basic needs because they cannot plan for their own needs. The congregate care takes place in the community as well as a hospital, but there is a need to increase the number of facilities that offer this care. It is not a popular type of care because patients do not get "cured".

A second type of patient is the patient that wanders because he is confused and disorientated. It is not safe for him to remain in the community without supervision. Most often he does not have the insight to recognize he needs protection. This is often the patient that is senile. The patient can be cared for in the community as long as there is an understanding that the patient needs the protection of supervision and a safe environment.

The third type of patient is the chronically assaultive patient. This patient, often presenting a complex mixture of organic and psychiatric factors, is a danger to himself and his caretakers unless they are skillful in handling assaultive patients. Mistakes in discharge planning and the absence of effective care facilities have serious effects for the patient, his family, and his community. The facilities that can care effectively for this type of patient are in scarce supply.

The fourth type of patient is the noncompliant patient who does not follow medical and psychiatric treatment recommendations. His resistance and opposition to treatment regimens can sometimes be altered with special programs but treatment requires skilled dedicated professionals and time.

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When these patients are discharged prematurely, they often cause problems to their families, their neighbors, and their communities.

The awareness of long-term care needs just began to develop in the VA Resource Allocation Models in the last year. It is difficult to document the problems of poor discharge planning. Our concern about the problem comes from contacts and letters from patient's relatives and neighbors when discharge planning is not effective. We believe that the community should be alerted to the problems.

In the past the VA has done an effective job caring for the chronic long-term psychiatric patient. While there is room for improvement of treatment facilities and methodologies, the purpose of my remarks is to remind you that our chronic patients and their need for care are still here and still present us with a challenge for future problem solving. It is essential that the DRG's Model include a consideration of the needs of the chronic psychiatric older patient.

With the implementation of a perspective payment system, incentives for hospitals were radically changed. The emphasis is on getting patients in and turning them around. When you have an elderly, medically compromised, psychiatrically compromised patient, this may not always work out. I will give specific examples, later in this report.

Our experience has been that we have a great deal of trouble with community placement. Again, you have a psychiatric population with severe medical problems, which means that the regular skilled nursing facilities and/or nursing homes and board and care homes are frequently reluctant to take many of these patients. They simply are not adequately reimbursed. Patients are now being prepared, at the beginning of their hospital stay, for discharge. However, the post-hospital care facilities which we have available for the psychiatric population is simply not adequate to meet the needs either

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in numbers or in the necessary secure environment. In addition, we have a significant population of what can only be termed chronic medical/psychiatrically ill patients, who cannot be discharged to any nursing home or board and care home (See case listing and Attachment A). These patients currently must be maintained in a VA facility. They are assigned a DRG with a chronic care rate, however, they do occupy an acute bed. This has some very negative consequences which we will discuss later. There have been some improvements and some very positive aspects of the implementation of DRG's in the Veterans Administration. For the average acute patient, the effect has been beneficial. The use of DRG's has served to sharpen the treatment team's decisiveness in treatment decisions, and certainly has expedited discharge planning. I believe that we are becoming more committed to whole health care, including the geropsychiatric patient.

One of the significant concerns of Veterans Administration Brentwood staff is the lack of secure nursing homes. The Veterans Administration construction program does not consider the need for psychiatric nursing homes, per se. This creates numerous complications since the medical model nursing home is not appropriate for secure care for the wandering patient, the assaultive patient, etc. Expensive modifications must be made after completion of a VA nursing home construction to assure a secure environment, if that unit is to provide care for many psychiatric patients. With the lack of available community psychiatric nursing home beds in the Los Angeles area, there are frequently long delays in finding appropriate facilities to accept the geropsychiatric and chronic psychotic patient with extensive subacute care needs, as well as those requiring extended periods of time. Therefore, these patients remain hospitalized in our acute care facility. Our general psychiatry wards are operating at over 90% occupancy rate, which results in delays of appropriate admissions.

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Some of the problems with our chronic psychiatrically impaired patients can be seen in the following sample case list:

1. A - This 66-year-old, non service-connected veteran has a diagnosis of Adjustment Reaction of Adulthood, and Schizotypical Personality Disorder. During his last nursing home placement in September 1983, this veteran was a very difficult management problem, striking at staff, spitting and urinating throughout the facility, and setting fire to towels. Currently, the veteran vomits and defecates indiscriminately throughout the ward, soils his clothing with feces, collects cigarette butts and ashes in his pockets and makes messes of them with water, and smokes unsafely, burning numerous holes in his clothing. It was suggested that he be referred to a special treatment program for treatment resistive patients, to work on improvement in targeted areas which would make him more placeable in the community.

2. B - This 72-year-old, non service-connected veteran has diagnoses of Dementia, Blindness, and Alcoholism. He was placed in a community nursing home (CNH) on June 6, 1984, and readmitted to Brentwood five days later after taking another patient hostage, barricading himself in his room with the hostage, kicking one nurse, and throwing another nurse against a wall. At the end of June, when he was reviewed for possible replacement in a community nursing home (CNH), staff reported that he continued to be very provocative toward staff and patients, noisy and upsetting to his peers, agitated, and assaultive toward staff.

3. C - This 86-year-old, 100% service-connected (bronchitis) veteran has diagnoses of Adjustment Disorder of Adulthood, Unclear Personality Disorder, Deafness, S/P cancer of the larynx with matastatic cancer to the lung, and S/P pneumonia. This veteran has a history of several failed nursing home placements due to difficult behavior and striking out. He was last placed on March 16, 1984 in a community nursing home (CNH), and was returned May 7, 1984

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because he became violent and a management problem. During the placement the veteran hit two nurses, and several patients, bit another nurse, and threatened others in the facility. He was verbally abusive and extremely manipulative with staff (Additional cases are listed in Attachment A).

Some additional information, in terms of the changing demographics of our contract nursing home patients can be seen on attachment B.

Another aspect of care for the elderly psychiatric patient is the cost of medications that are necessary on a daily basis. Frequently, these patient's hospital medications at a VA facility will cost approximately five to six dollars a day. This cost is based on the VA's very inexpensive, nationwide buying system price. At most private or community facilities, the same drugs would cost minimally four to six times the VA amount.

Brentwood is in the process of developing an integrated approach to the Quality Assurance and Utilization Review functions, using DRG methodology to monitor the services. Currently, our computer systems are not sufficiently sophisticated to adequately provide assistance. We currently perform a great deal of manual monitoring and concurrent chart reviews, for both Quality Assurance and Utilization Review. We propose devoting additional resources to both the current manual review and computer availability. We will be focusing on both the parameters of under-utilization and over-utilization. We will be looking both at individual cases and the patterns of practice that reflect on either quality or the utilization, and these patterns for individual care providers will be reviewed and appropriate action taken. Currently, the Utilization Review is done on a case by case basis with action as necessary.

A number of other areas which I believe need to be called to the Committees attention are the effects of DRG's on placement of the terminally ill. Currently, there is no DRG for the terminally ill. We find that, generally, nursing homes do not wish to maintain the terminally ill in their

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facility and therefore refer the terminally ill back to the acute hospital for care. It is frequently medically inappropriate to have an acute care bed occupied by a terminally ill patient. Hospice care is needed; not acute care. It may be appropriate to consider development of either hospice care DRG's and/or an increase of hospice care beds.

An additional aspect of concern is the training provided staff and students in both geriatric medicine and geropsychiatry. We have extensive training programs for residents, social workers, psychologists, etc., to work with the geriatric population. This is necessary in order to provide adequate education and commitment. We are developing a teaching nursing home at West Los Angeles. I do want to emphasize that one urgent need is to provide additional "hands on" care for the elderly. We cannot afford to do this under the present DRG reimbursement payment system.

I would also like to iterate information I am sure that the Committee is familiar with, the recent study by the National Association of Private Psychiatric Hospitals (NAPPH). That report stated that the current DRG's for mental illness and substance abuse cannot accurately gauge consumption of hospital services, a conclusion that affirms the results of similar studies conducted by APA and Johns Hopkins University researcher Susan Horn. The current DRG's for mental illness and substance abuse are based on data from psychiatric units in general hospitals, which tend to treat patients suffering from acute episodes, the report points out. In contrast, private psychiatric hospitals frequently treat severely ill patients or those with previous psychiatric hospitalizations who require much longer hospital stays.

After collecting the data, the NAPPH team first analyzed the DRG's reduction in variance (RIV), that is, their ability to predict length of stay, for patients at private psychiatric hospitals. Like other researchers they found an unimpressive RIV of only 3.92 percent. Subdividing the DRG's

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according to age groups slightly improves the system's predictive ability, the study states. Other attempts to refine the DRG's, such as taking into account secondary diagnoses, also resulted in marginal improvement.

Significant characteristics which affect treatment of psychiatric patients are age, patients who have been treated/transferred at another psychiatric facility, presence of psychiatric complications and comorbidities; such as involuntary commitment, referral from prison or courts; history of attempting suicide or assaulting patient, or hospital staff member, or family member; need for seclusion or physical restraint, elopement from the hospital, or wandering behavior.

Our nation is committed to health care for our population, within a reasonable cost containment program. Psychiatric DRG's and DRG's for care of elderly or terminal patients need, I believe, further careful consideration.

I hope that this information will be of use in your consideration of this significant program.

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ATTACHMENT A

1. A - This 64-year-old, 10% service-connected veteran has a diagnosis of Alzheimer's Disease. He is extremely impulsive and is often hostile and assaultive. Between the dates of March 19, 1984 and April 25, 1984, this veteran assaulted or attempted to assault others 18 times. Veteran strikes without warning at staff, patients, and visitors on the ward. He is currently being tried on various medication regimens to attempt to decrease his assaultiveness, and increase his placeability. It was recommended that re-referral be made for placement if veteran is unassaultive for a 4-week period.

2. B - This 57-year-old, 100% service-connected veteran was hospitalized for many years at Camarillo State Hospital due to his difficult, assaultive behavior. After 6 months on a special treatment program, the veteran was placed February 1984 in a board and care home. He physically attacked the owner of the home and was returned to Brentwood. Veteran continues to be assaultive on the ward. He has struck 2 people and attempted to strike other staff. Veteran has been placed in 4 point restraints by ward staff numerous times for assaultive, hostile behavior.

3. C - This 68-year-old, 30% service-connected veteran has a diagnosis of Dementia of Mixed Etiology. The veteran has been living in the VA almost continuously for the past two years due to his violent behavior. He was placed in a community nursing home (CNH) on May 7, 1984, and was returned seven days later for hospitalization after he became violent, striking another patient in the nursing home, and resulting in a lawsuit against the nursing home by the family of the injured patient. At the end of June, when he was reviewed for possible replacement, he was reported by staff to be extremely

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territorial and intolerant of peers or staff who intrude upon the area he has defined as his own. Staff reported that the patient continued to strike out without warning, and that he had recently attacked a staff member, applying a choke hold on the staff member and holding a knife at the employee's neck.

4. D - This 59-year-old, non service-connected veteran has a diagnosis of Schizoaffective Disorder. He has lived at Brentwood almost continuously since 1982 due to his difficult, demanding behavior. On the ward, he exhibits a very low frustration tolerance, becomes easily agitated and verbally abusive, refuses to conform to ward rules and procedures, and exhibits infantile tantruming behavior when angered or upset. He periodically cross dresses in female clothing, but has not acted out sexually in any other way. This patient has a history of poly drug abuse and numerous failed community placements. Referral for community nursing home (CNH) placement was attempted in May, 1984, but was abandoned by the ward when the veteran climbed to the top of one of the Brentwood buildings and threatened to jump.

5. E - This 60-year-old, 100% service-connected (Psychiatric Condition) veteran has a diagnosis of Schizophrenic Disorder, Chronic, and Organic Brain Syndrome secondary to Frontal Lobotomy. He was an inpatient at Brentwood from 1944-1970 due to his violent behavior. During the period 1970-1984, the veteran was placed repeatedly in CNH's and has been repeatedly readmitted due to sudden, unprovoked violence. He has a history of aggressive behavior, verbal outbursts, severe memory impairment, and lack of impulse control secondary to his lobotomy in 1949 to control his violence. The veteran was replaced on June 27, 1984 in a community nursing home (CNH) and has been readmitted to Brentwood.

6. F - This 67-year-old, non service-connected veteran has diagnoses of Dementia, Chronic Alcohol Abuse, COPD, and S/P Myocardial Infarction (Hypertensive). The veteran has a long history of alcohol abuse, and a

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history of progressive dementia for 10 years. His behavior is often difficult to manage, with striking out behavior, agitation, and loud, verbally abusive language. The patient was placed on February 24, 1984 in a community nursing home (CNH), and was returned May 29, 1984 to a crisis ward for unmanageable behavior in the nursing home. During his placement, he was very resistant to staff attempts to assist him with his ADL, was very loud and verbally abusive toward staff, peers, and visitors to the facility, and repeatedly pushed his hospital bed across the bedroom door, blocking the exit. He was returned to the VA after physically attacking a facility nurse, who has threatened to sue the nursing home for accepting a violent patient into the facility (patient now deceased).

7. G - This 48-year-old, non service-connected veteran has a diagnosis of chronic Schizophrenia, and has a long history of poly drug abuse and sexual acting out. He has a history of lengthy hospitalizations in various VA and state hospitals dating to the 1950's. He has been almost continuously hospitalized for the past 13 years, with numerous transfers to locked crisis units for threatening and belligerent behavior. The veteran is a registered sex offender, and he is still currently sexually aggressive towards female staff. He has a long history of substance abuse, and is documented as using drugs on the VA grounds, if he obtains access to them. Veteran was treated in the Behavior Improvement Program (BIP), and is currently on an open ward. In May and June, 1984, attempts were made to place him in the five closed community nursing home (CNH) settings near the Brentwood catchment area. He was refused by all CNH's as too dangerous and inappropriate for nursing home placement.

8. H - This 39-year-old, 100% service-connected (Psychiatric Condition) veteran has a diagnosis of Paranoid Schizophrenia. The veteran has a history of 16 years of almost continuous hospitalization due to his aggressive,

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paranoid behavior, and sexual acting out. Veteran has been arrested in the past for exhibitionism, and has a history of voyeurism (peeping) and open masturbation. He currently becomes agitated and behaviorally escalates about three times per week, requiring staff intervention to avoid violence. The veteran has a substance abuse history, and is know to drink alcohol when he is on pass. The veteran continues to be delusional at times, and becomes easily agitated in response to internal stimuli unrelated to his environment. He continues to feel sexually stimulated by watching female staff members, and masturbates in the men's room while watching them on the ward.

9. J - This 59-year-old, non service-connected veteran has a diagnosis of Pick's Disease. The veteran has a gradual history of intellectual and behavioral deterioration secondary to Pick's Disease. He is very restless and becomes irritable and agitated; he must be restrained to rest or he will pace to exhaustion. The veteran requires several staff to restrain him during bathing and has an insatiable appetite due to his disease. During this admission, the patient found a way to climb into the crawl space in the ceiling of the ward, and was found when he fell through the ceiling in the day room. On July 3, 1984 an attempt at placement was made, but was cancelled when the patient became so agitated in the outpatient exit of Wadsworth that he could not be restrained or transported to the community nursing home (CNH). On July 5, 1984 the patient was sedated for the trip to the CNH, but after arrival at the CNH the patient's behavior became uncontrollable. He was returned to Brentwood after exhibiting very agitated, accelerated behavior, including lifting a refrigerator off the ground, and stealing and eating five trays of food taken from other patients.

10. K - This 61-year-old, non service-connected veteran has a diagnosis of Huntington's Chorea with dementia. He is currently a total bed care patient who is incoherent, and who has severe, almost constant, choreic

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movements of his extremities. This veteran currently requires four point restraint at all times in his bed, and the bed has had to be modified to adjust to the veteran's constant movement and flailing of extremities. Although the veteran's bed is heavily padded, the skin on his legs is injured from the constant banging of his extremities against his bed area. The skin injuries include oozing scabs and sheet burns. The veteran is fed through an N/G tube due to his difficulty with swallowing. The veteran must be very closely monitored, and the medication to control his choreic movements must be adjusted relative to the amount of respiratory distress he is experiencing.

11. L - This 63-year-old, 80% service-connected veteran has a diagnosis of Bipolar Affective Disorder (Hypomania) and Borderline Personality disorder. The veteran has a long history of antisocial and sociopathic acts such as arms smuggling, wrecking police cars with his car, setting fires in his hospital room, threatening hospital staff with a weapon, and numerous assaults on others. The veteran has been in nursing homes two times in the past 1 1/2 years. In one he was verbally abusive, assaulted the charge nurse, and reported the facility to the police saying he had been robbed. In the last community nursing home (CNH) facility in July, 1983, the veteran refused to follow the rules in the facility, came and went as he pleased without approval, reported the facility to the police claiming that a prostitution and drug ring operated there, smoked unsafely and in inappropriate areas, was verbally abusive, and, finally, had to be forcibly removed from the facility by the police after grabbing the telephone from administrative personnel in the office and screaming complaints about the facility to the State Licensing Surveyor on the telephone.

12. M - This 49-year-old, 100% service-connected (Schizophrenia) veteran has diagnoses of Schizophrenia, disorganized type, and Seizure Disorder. This veteran has been hospitalized almost continuously since his discharge from the

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service in 1954. He has a history of repeated elopement from community nursing home (CNH) placement and from Brentwood. The veteran returns from these community elopement periods in a highly delusional, deteriorated and disheveled state, and takes many months to restabilize in the hospital. He was referred for treatment to the Treatment Refractory Unit, was referred back after treatment to an open ward, and was replaced June 25, 1984 in CNH. This patient has been placed four times in the past year, and always elopes from the facility to live in a deteriorated state on the streets.

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ATTACHMENT B

CHANGING CHAPACTERISTICS OF BRENTWOOD DIVISION CONTRACT NURSING HOME PATIENTS 1983 - 1985

AGE	1983	1985
Under 55	34%	20%
55-64	34%	40%
65-74	28%	33%
75-84	4%	7%
85+	--	--

MARITAL STATUS	1983	1985
Married	16%	26%
Single	56%	44%
Divorced/ Separated	22%	23%
Widowed	6%	7%

ELIGIBILITY STATUS	1983	1985
SC	62%	53%
NSC	38%	47%

TYPE OF PLACEMENT	1983	1985
Open NH	26%	31%
Closed NH	74%	69%

75% of Brentwood CNH patients have a medical diagnosis

53% have a dementia diagnosis

DIAGNOSES	1983	1985
Psych only	64%	11%
Psych/ Medical	36%	36%
Psych/ Dementia		10%
Dementia/ Medical		23%
Dementia Only		4%
Psych/ Dementia/ and Medical		16%

SOCIAL WORK SERVICE STATEMENT FOR CONGRESSIONAL HEARING ON
THE EFFECT OF DRG'S ON THE GERO-PSYCHIATRIC PATIENT

My comments represent the opinion of the Social Work staff of the Brentwood Division of West Los Angeles Veterans Administration Medical Center. Brentwood is the VA psychiatric hospital in West Los Angeles.

Social Work Service is concerned about the application of DRG'S and the impact on patient care. In some ways we have been pleasantly surprised. For the average acute patient the effect has been beneficial. The use of DRG'S has served to sharpen the treatment team's decisiveness in treatment decisions, particularly discharge planning. We have been able to shorten the length of stay and return patients to the community earlier.

However, there are several types of patients that are adversely affected by the application of DRG'S. These are the chronic patients with complex psychiatric and medical problems that do not respond to acute treatment methodologies. Their treatment needs are not quickly resolved. Their conditions are chronic and complex. I would like to breifly describe some of these types because the impact of dealing with these problems in ineffective ways has serious implications in creating social problems that affect the community.

There are 4 types of older psychiatric patients that I would like to mention: the organically disabled, the waundering patient, the chronically assaultive patient, and the non-compliant patient. These groups of patients are inter-related. They are not diagnostic groups. They describe problem behavior that require care, protective care. These are patients that develop only limited insight and understanding of their behavior.

The organically disabled are patients that may have a variety of diagnoses such as Alzheimers or other dementias. A small number are patients that received lobotomies years ago. They are gravely disabled. They do not have sufficient judgment to handle their own care needs. Many do not have families to plan their care. If these patients are discharged with poorly thought-out plans they become some of the "homeless" that crowd our streets. These patients need congregate care that provides for their basic needs because they cannot plan for their own needs. The congregate care take place in the community as well as a hospital but there is a need to increase the number of facilities that offer this care. It is not a popular type of care because patients do not get better or "cured".

The awareness of long term care has just begun to develop in the Resource Allocation Models in the last year. It is difficult to document the problems of poor discharge planning. Social Work Service's concern about the problem comes from contacts and letters from patients' relatives and neighbors when discharge planning is not effective. We believe that the community should be alerted to the problems.

A second type of patient is the patient that waunders because he is confused and disoriented. It is not safe for him to remain in the community without supervision. Most often he does not have the insight to recognize he needs protection.

This is often the patient that is senile. The patient can be cared for in the community as long as there is an understanding that the patient needs the protection of supervision and a safe environment.

The third type of patient is the chronically assaultive patient. This patient, often with a complex mixture of organic and psychiatric factors, is a danger to himself and his caretakers unless they are skillful in handling assaultive patients. Mistakes in discharge planning and the absence of effective care facilities has serious effects for the patient, his family, and his community. The facilities that can care effectively for this type of patient are rare and in scarce supply.

The fourth type of patient is the non-compliant patient who for reasons organically or psychiatrically does not follow medical and psychiatric treatment recommendations. His resistance and opposition to treatment regimes can sometimes be altered with special programs but treatment requires skilled dedicated professionals and time. When these patients are discharged prematurely, they often cause problems to their families, their neighbors, and the communities.

In the past the VA has done an effective job caring for the chronic long term psychiatric patient. While there is room for improvement of treatment facilities and methodologies, the purpose of my remarks is to remind you that our chronic patients and their need for care are still here and still present us with a challenge for future problem-solving. It is essential that the DRG'S Model include a consideration of the needs of the chronic psychiatric older patient.

EDITH F. PEARSON, MSW, ACSW
Chief, SWS
Brentwood Division
West Los Angeles VAMC

CALIFORNIA MEDICAL ASSOCIATION
TESTIMONY BEFORE THE SPECIAL COMMITTEE ON AGING, UNITED STATES SENATE
Senator Wilson presiding

Senator Wilson, thank you for the opportunity to present written testimony to the Special Committee on Aging in connection with your hearing in Los Angeles on January 7, 1986. I am Laurens P. White, M.D., Chairman of the Council of the California Medical Association. The Council is our Board of Trustees. I am an internist and Medical Oncologist in practice in San Francisco, and am a Clinical Professor of Medicine at the University of California Medical School in San Francisco. I chair the Medicare Committee of the CMA, and serve as consultant to our Special Committee on Aging.

The California Medical Association is committed to efforts to assure that Medicare recipients receive necessary and appropriate care of the highest quality, the care that patients of any age and any ability to pay should expect and should demand. We support your efforts in this direction. We also support the concept of peer review, coordinated on a statewide basis, and we made a strong, although unsuccessful, effort to become the PRO for California. We are meeting on an ongoing basis with representatives of California Medical Review, Inc. (CMRI), the California PRO, to help assure appropriate review. We believe these review efforts would be greatly improved if HCFA would change its unilateral ruling and allow the PRO to communicate cases of questionable quality of care to hospital medical staffs. Without the ability of the hospital staff to participate in the process of review, the whole concept of peer education, and peer review, is undermined. Unfortunately, this HCFA ruling has also put CMRI (the PRO) in a strange position of being unable to do anything to avoid problems of assuring quality care, and cast them in the role of policemen whose primary tools are retroactive denials of care and sanctions against physicians or hospitals.

We have been encouraging our physicians to continue to be advocates for their patients and to insist that their patients receive the care they need, regardless of opinions of any agency or group. Pressure to change this advocacy, and these decisions for quality care, is coming from all sides. The PRO refuses to authorize admissions for certain conditions or procedures, they refuse to authorize "outlier days" on the basis that the care can be provided at a lesser level and retroactively deny cases when, in their opinion, the patient was discharged too early.

Hospitals are looking very carefully at utilization of hospital resources to assure that expenses do not exceed income. Many of these efforts are legitimate, but patients and their families have expectations about the need for in-hospital care and physicians have a knowledge of needs and dangers. This knowledge is based on knowing the patient's medical/socio/environmental history and the current medical problem. The medical record doesn't always include this information. In fact, it can't capture the intuition based on experience and the art of medicine. Attending physicians must constantly be on the alert to pressure and be sure that when questioned they can explain the patient's needs and be willing to insist upon services that others may think are not needed. The responsibility for the patient rests with the physician. That responsibility cannot be delegated to anyone else. If a physician does not make good decisions, patterns of problems will indicate a need for peer education. If that doesn't work, then disciplinary action is needed at the medical staff level and perhaps by Medicare and the licensing agency.

Most of the problems that the PRO and physicians face when they try to do what is right for a Medicare patient are caused by over-rigid laws and regulations. Where is it proper for a patient to die? This decision cannot be made by fiat. Each case will depend on the patient, community resources, family and community expectations. It is a sad commentary on Medicare which encouraged unnecessary treatment during a terminal stay to justify an appropriate and humanitarian stay in the hospital during the last hours of a senior citizen's life. A solution is needed.

Another and more difficult issue is the three-day acute hospital stay requirement for the patient to be eligible for SNF benefits. There must be some way to qualify a patient for SNF level of care rather than the artificial and expensive three-day requirement. This could be an appropriate activity for the PROs.

There is no question that Medicare patients are being discharged earlier than before DRGs. In many cases that is inappropriate, especially when there are inadequate services in the community to do those things that hospitals provided in the past. SNF and home health services must be improved to provide needed

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care in fact, not just in theory. PROs must have authority to look at the whole situation in a community and judge whether or not the patient could have received the post-hospital care that was needed. Again, fixed rules can't be used. Additional reimbursement must be provided to hospitals that, for the welfare of the patient, must provide post-hospital care that is not available in the community. Government auditors must be instructed that they must not evaluate PRO performance based on rigid formula or definitions of level of care. PRO decisions, like attending physician decisions, can only be evaluated based on all facts and the needs of the individual patient.

Furthermore, relying on retroactive denials and sanctions to educate physicians and hospitals is disruptive, costly and not effective. Most problems in medical care can be resolved by peer education. This education is most effective when provided in the hospital medical staff setting. Most physicians must have hospital privileges to practice medicine. They do not want to jeopardize their privileges and will change their practices to conform with medical staff standards. The proper role of the PRO is to review sufficient cases to be sure that care provided in the hospital is complete, proper and needed. If problems are detected or suspected, the PRO should ask the medical staff to deal with them. If the medical staff or a physician does not correct practice problems based on education, then denials and sanctions are in order. In California, and under Medicare Conditions of Participation and JCAH Standards, a hospital is very vulnerable if its medical staff is not effectively being responsible for the quality of medical services in the hospital.

For the record, I must state that the number of quality of care problems that our PRO has found in California have been very few. The Quality Objectives were vastly overstated. Focused and thorough review by the PRO did not find 1.06% of the problems that they expected to find. Not only did the Objectives not find the expected problems, review of more than 40% of all Medicare discharges and application of stringent quality screening criteria found relatively few quality problems. We must conclude that the problems do not exist in great numbers.

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PRO contracts must be revised to permit cost-effective focusing of review where there are real and significant problems. Review of 40% or even 10% of cases where findings are relatively insignificant is a waste of money. As indicated earlier, there are a number of valuable and productive activities that a PRO can perform to help patients receive the care that they need and to help HCFA administer a more flexible and realistic program of Medicare coverage. An impartial professional review organization can make administrative decisions about individual needs and appropriate additional reimbursement.

Finally, from its beginning in 1966, Medicare has promised patients necessary medical services of high quality. This has been a good program that has enabled our senior citizens to receive needed acute hospital care; however, increases in deductibles and coinsurance are pushing expenses higher and are becoming a burden to patients. CMA is concerned that the value of Medicare coverage not be eroded further by:

1) cuts in service made solely to contain expenditures;
2) shifting the burden of Medicare costs to private sector employers or employees, or to beneficiaries through increased co-payments and/or deductibles.

The federal government must fund the Medicare program adequately and maintain the essential services it covers, giving these services priority over deficit reduction schemes, in keeping with the federal commitment to the program's goal: to provide accessible, high-quality medical care for Americans age 65 and over. Co-payments and deductibles must not increase. Maintaining Medicare benefit levels and removing artificial barriers to post acute-hospital care will contain costs without depriving Medicare beneficiaries of needed care. The short term, easy way to contain cost is to deny access to quality care, but that will result in more patients eventually requiring more expensive medical care and suffering unnecessarily. The California Medical Association and the Congress of the United States cannot condone that sort of cost containment.

Thank you again for the opportunity to present these observations. We will be pleased to elaborate on any of the points that we touched on. We want the Medicare program to continue to provide coverage for medically necessary and appropriate services. We will work with you, the Select Committee on Aging, HCFA and California Medical Review, Inc. (CMRI) to meet this goal.

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